Third Party Liability Unit

INDIANA HEALTH COVERAGE PROGRAMS

Teleprocessing Users Guide- Buy In

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Section 1: Medicare Coverage Window

Introduction

IFSSA and EDS use the Medicare Coverage window to view or update the Medicare Part A and Part B. The Medicare Coverage window contains the Medicare Part A and Part B effective dates, end dates, and the Carrier Number along with the HIB History. Update capability is assigned to specific users. The HIB must be saved before updating the Medicare history. Access the Medicare Coverage window from any window by selecting the Options tool and clicking **Medicare** and then **Medicare Coverage**, or to use the keyboard, press **Alt + O**, then **M**, and **M** one more time.

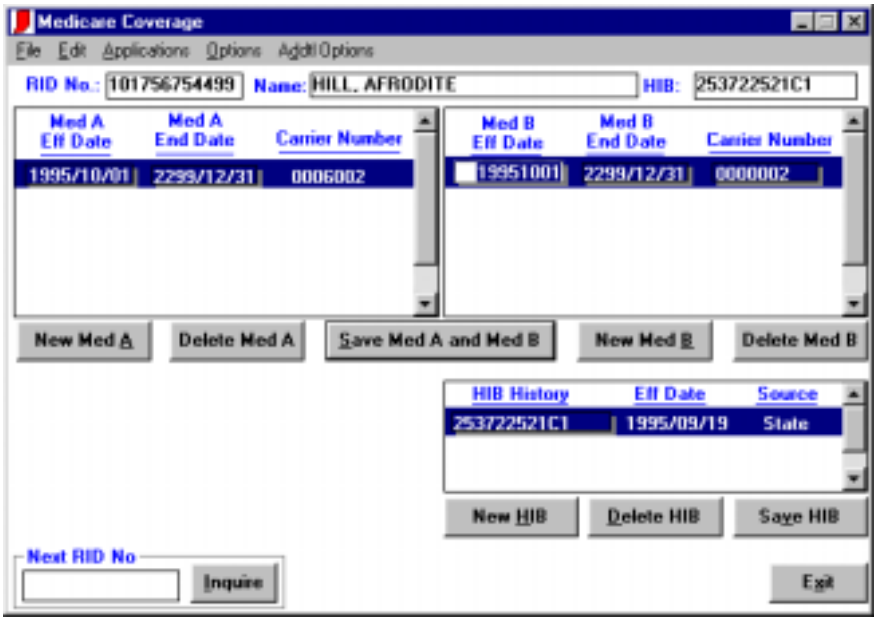

Figure 1.1 – Medicare Coverage Window

File	Edit	Applications	Options	
New Med A	Copy	Adhoc Reporting	**Base**	**Standard**
New Med B	Paste	Claims	Eligibility	Replacement
Save	Cut	Financial	Previous	
Print		Managed Care	LOC	Name
Exit		MARS	Patient Liab	PCNs
Exit Indiana*AIM*	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift+Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 1.2 - Medicare Coverage Menu Tree

Figure 1.2 is an illustration of the menu tree for the Medicare Coverage window menu tree. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Medicare Coverage window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, and **Options** have the same functions in all the member windows.

Menu Selection: File

These commands save changes made to the Medicare Coverage window, print the window, exit the Medicare Coverage window, audit, and exit Indiana*AIM*.

New Med A – Adds a new Medicare Part A segment.

New Med B – Adds a new Medicare Part B segment.

Save – Saves changes made to window.

Print – Prints the window.

Exit – Exits the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands make adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Paste text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURS – Accesses SURS

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial

Format – 29 alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Med A Eff Date

Description –Medicare Part A effective date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 4011 – Effective date must be earlier than or equal to the end date!

To Correct – Verify date and date format and re-enter.

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Edit – 91030 – Date segments may not overlap!

To Correct – Verify date and re-enter.

Field Name: Med A End Date

Description – Medicare Part A end date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Field Name: Carrier Number

Description – Medicare A carrier number

Format – Seven numeric characters

Features – Protected – Auto-plugged with 0006002

Edit – None

To Correct – N/a

Field Name: Med B Eff Date

Description – Medicare Part B effective date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 4011 – Effective date must be earlier than or equal to the end date!

To Correct – Verify date and date format and re-enter.

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Edit – 91030 – Date segments may not overlap!

To Correct – Verify date and re-enter.

Field Name: Med B End Date

Description – Medicare Part B end date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Field Name: Carrier Number

Description – The Medicare B carrier number

Format – Seven numeric characters

Features – Drop-down list box

Valid values:

0000002

0008035

0011641

Edit – None

To Correct – N/a

Field Name: History HIB

Description – Member's current or previous Medicare ID number

Format – 12 alphanumeric characters

Features – None

Edit – 4025 – Invalid HIB

To Correct – Verify entry and re-enter. Refer to the *Buy-In Manual* for correction for valid HIB format.

Field Name: Eff Date

Description – The HIB effective date

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected – Defaults to current date

Edit – None

To Correct – N/a

Field Name: Source

Description – Represents the source the added Medicare ID.

Valid values:

H – HCFA

I – ICES

S – State

Format – One alphabetic character

Features – Protected – Defaults to State

Edit – None

To Correct – N/a

Other Edits

4172 – Medicare ID (HIB) must be present! Occurs when the user attempts to add Buy-In A History or Buy-In for both coverage period for a member with no HIB.

91014 – Do you really want to delete this record? Warning message that occurs when the user attempts to delete an existing HIB from history.

System Information

PBL – RECIP02.PBL

Window – W_RE_MEDICARE_COV

Data Windows – DW_MEDICARE_A

DW_MEDICARE_B

DW_RE_HIB_HEADER

DW_PREV_HIB

Menu – M_RE_MAINTENANCE

System Features

New Med A at the middle of the Medicare Coverage window adds a new Medicare Part A segment.

New Med B at the middle of the Medicare Coverage window adds a new Medicare Part B segment.

Save Med A and Med B saves changes to the window.

New HIB adds a new HIB.

Delete HIB deletes an HIB segment after it has been highlighted.

Delete HIB removes an existing HIB.

Save HIB saves changes made to the HIB History.

Exit closes the window.

Section 2: Buy-In Coverage Window

Introduction

IFSSA and EDS use the Buy-In Coverage window to view or update the Buy-In Part A and Part B information for a member. The Buy-In Coverage window contains the Buy-In Part A and Part B eligibility information. Update capability is assigned to specific users. Access the Medicare Coverage window from any window by selecting and clicking **Medicare** and then **Buy-In Coverage** under the **Options** tool or, use the keyboard and press **Alt + O**, then **M,** then **B**.

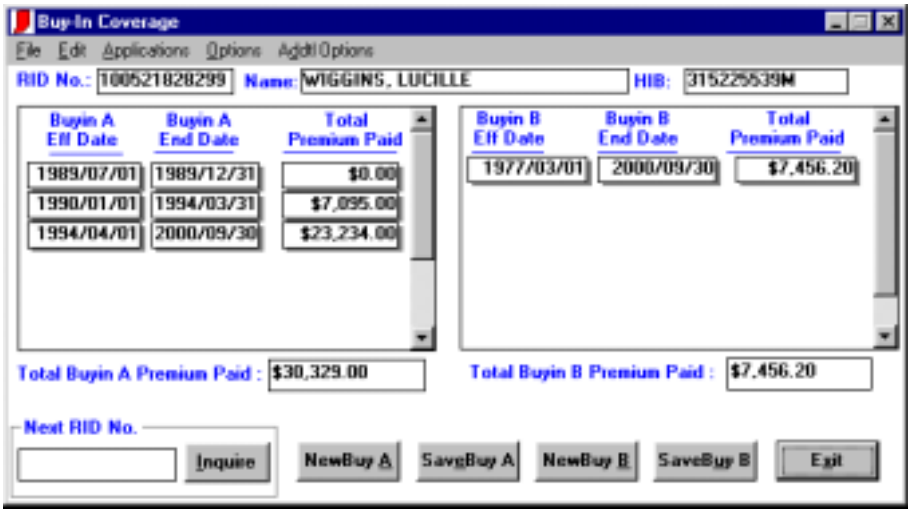

Figure 2.1 – Buy-In Coverage Window

File	Edit	Applications	Options	
New	Copy	Adhoc Reporting	**Base**	**Standard**
Print	Paste	Claims	Eligibility	Replacement
Exit	Cut	Financial	Previous	
Audit		Managed Care	LOC	Name
Exit Indiana*AIM*		MARS	Patient Liab	PCNs
	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift +Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 2.2 - Buy-In Coverage Menu Tree

Figure 2.2 is an illustration of the menu tree for the Buy-In Coverage window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Buy-In Coverage window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, **Options** and **Addtl Options** have the same functions in all the member windows.

Menu Selection: File

These commands add a new Buy-In Coverage, save changes made to the Buy-In Coverage window, delete Buy-In Coverage, print the window, exit the Buy-In Coverage window and exit Indiana*AIM*.

New – Adds a new Buy-In Part A segment

Print – Prints the window

Exit – Exits the window

Audit – Audit changes made to the Medicare Buy-in Window

*Exit Indiana*AIM – Exits from Indiana*AIM*

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy– Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURS – Accesses the SURS information.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial

Format – 29 alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/A

Field Name: Buy-In A Eff Date

Description – Buy-In Part A effective date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 4011 – Effective date must be earlier than or equal to the end date!

To Correct – Verify date and date format and re-enter.

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Edit – 91030 – Date segments may not overlap!

To Correct – Verify date and re-enter.

Field Name: Buy-In A End Date

Description –Buy-In Part A end date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Field Name: Total Premium Paid

Description – Total premium amount from the Billing A Tape

Format – Eight numeric characters

Features – None

Edit – 91006 – Field is required!

To Correct – A valid value must be entered.

Edit – 91007 – Data must be numeric.

To Correct – Verify entry. Key a numeric value

Field Name: Buy-In B Eff Date

Description – Buy-In Part B effective date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 4011 – Effective date must be earlier than or equal to the end date!

To Correct – Verify date and date format and re-enter.

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date in (CCYY/MM/DD)

Edit – 91030 – Date segments may not overlap!

To Correct – Verify date and re-enter.

Field Name: Buy-In B End Date

Description –Buy-In Part B end date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91002 – Date must be numeric!

To Correct – Verify entry and re-enter date in CCYY/MM/DD format.

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Field Name: Total Premium Paid

Description – Total premium amount from the Billing A Tape

Format – Eight numeric characters

Features – None

Edit – 91006 – Field is required!

To Correct – A valid value must be entered.

Edit – 91007 – Data must be numeric.

To Correct – Verify entry. Key a numeric value

Field Name: Total Buy-In A Premium Paid

Description – The total amount of all the premiums for Buy-In Part A

Format – Eight numeric characters

Features – Protected – Display value up to $9,999,999.99

Edits – None

To Correct – N/a

Field Name: Total Buy-In B Premium Paid

Description – Total amount of all the premiums for Buy-In Part B

Format – Eight numeric characters

Features – Protected – Display value up to $9,999,999.99

Edits – None

To Correct – N/a

Field Name: Next RID No

Description – Opens the Buy-In Coverage window for another member

Format – 12 numeric characters

Features – None

Edit – 91007 – Must be numeric

To Correct – Verify entry. The RID No. must be 12 numeric characters

Edit – 91046 – New key is required.

To Correct – An entry is required in order to search for a member. Key in a valid RID No.

Edit – 4100 – No match found.

To Correct – Enter a valid RID No. There was not a match in the member file for the ID keyed.

Other Edits

Member must be QMB or QDWI to add Buy-in Part A. Occurs when the user attempts to add Buy-in A coverage for a member who is not QMB or QDWI.

HIB –suffix must be M, J3, J4, K3, or K4. Occurs when the user attempts to add Buy-In A coverage for a member who has a HIB with a suffix other than those listed in the error message.

4172 – Medicare ID (HIB) must be present! Occurs when the user attempts to add a Medicare coverage period for a member with no HIB.

4179 – Member has Buy-In A during this time period. Occur when a Medicare coverage period is changed, and the user to no longer fully encompass the corresponding Buy-In A coverage period.

4180 – Member has Buy-In B during this time period. Occur when a Medicare coverage period is changed, and the user to no longer fully encompass the corresponding Buy-In B coverage period

System Information

PBL – RECIP02.PBL

Window – W_RE_BUY-IN_PERD

Data Windows – DW_RE_BUYA_PERD

DW_RE_BUYB_PERD

DW_RE_HIB_HEADER

Menu – M_RE_MAINTENANCE

System Features

New Buy A at the bottom of the Buy-In Coverage window allows the user to add a new Buy-In Part A segment.

New Buy B at the bottom of the Buy-In Coverage window allows the user to add a new Buy-In Part B segment.

Save Buy A saves changes made to the Buy-In Part A on the window.

Save Buy B saves changes made to the Buy-In Part B on the window.

Exit closes the window.

Section 3: Buy-In A Billing Window

Introduction

IFSSA and EDS use the Buy-In A Billing window to view the transactions sent by HCFA on the Buy-In A Billing Tape. The Error field on the Buy-In A Billing window is the only field that can be updated by specified users. The same users have the capability to drag records from the Billing A Mismatches window to the Buy-In A Billing window after the mismatches are researched and resolved.

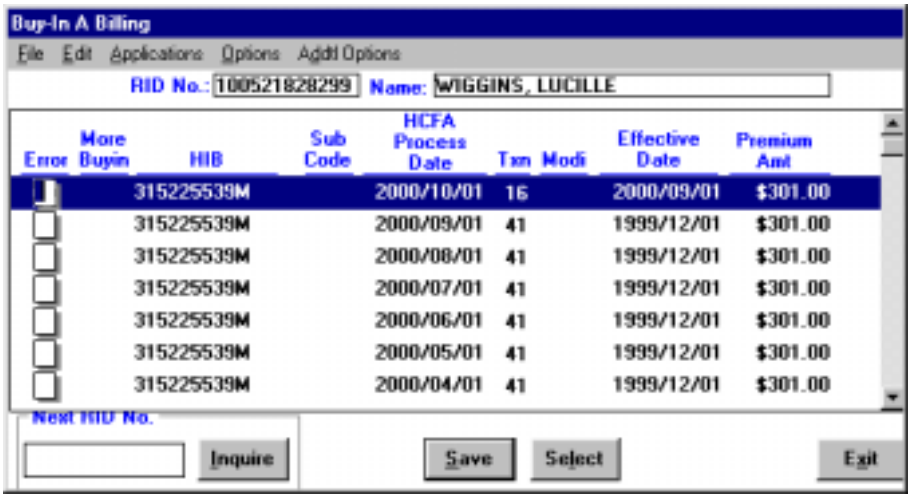

Figure 3.1 – Buy-In A Billing Window

File	Edit	Applications	Options	
Print	Copy	Adhoc Reporting	**Base**	**Standard**
Exit	Paste	Claims	Eligibility	Replacement
Audit	Cut	Financial	Previous	
Exit Indiana*AIM*		Managed Care	LOC	Name
		MARS	Patient Liab	PCNs
	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift +Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 3.2 - Buy-In A Billing Menu Tree

Figure 3.2 is an illustration of the menu tree for the Buy-In A Billing window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Buy-In A Billing window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, and **Options** have the same functions in all the member windows.

Menu Selection: File

These commands print the window, exit the Buy-In A Billing window, audit and exit Indiana*AIM*.

Print – Prints the window.

Exit – Exits the window.

Audit – Audits changes to the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURS – Accesses the SURS information.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial

Format – 29 alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Error

Description – Updated by the user to indicate whether the Billing record applied to the wrong member.

Format – One alphabetic character

Features – None

Edit – 91026 - Data must be **Y** or **N**

To Correct – Verify entry, data must be **Y** or an **N**

Field Name: More Buy-In

Description – Indicates whether there is more Buy-In Billing information kept on file because of a mismatch between HCFA and the Indiana MMIS.

Format – One alphabetic character

Features – Protected – Double-click to open a pop-up window with more Buy-In B information for the member when the More Buy-In is **Y**.

Edits – None

To Correct – N/a

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Sub Code

Description – Applicable to a rejected accretion record (code 21xx), a duplicate accretion or deletion record (25xx), or a State submitted accretion record that matches a death deletion (code29xx)

Format – One alphabetic character

Features – Protected

Edits – None

To Correct – N/a

Field Name: HCFA Process Date

Description – Date the Buy-In Part A Billing tape processed

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edits – None

To Correct – N/a

Field Name: Txn

Description – Buy-In Part A transaction code. It is the first two characters of the four-character numeric code. This code represents either a response to a transaction the State sent or a transaction initiated by HCFA.

Format – Two numeric characters

Valid values:

Code	Code	Description
11	XX	Code 11 informs the State that the individual accreted to Medicare that results in a debit action to the State. The State is liable for the individual's premium and is billed monthly.
11	25	Accretion is adjusted to a later date
11	28	Inform the State that the effective date in an accretion submission was adjusted by the Third Party System to show a later date. The TPM showed a closed coverage period for a different State.
11	61	Informs the State that the individual accreted to Medicare. The effective date is the same as reported, except when a code 30 is present.
14	bb	Informs the State that HCFA deleted the Part A third party record.
15	bb	Informs the State that the individual was deleted from State's buy-in account because SSA's records indicate that the individual does not meet all the requirements for Medicare.
16	bb	Informs the State that according to SSA's records, the individual is deceased and was deleted from the State's buy-in account. To reaccrete, the State must obtain corroboration in writing from Social Security Office (SSO).
17	XX	Informs the State that HCFA deleted the Part A third party record. The deletion may represent an internal adjustment by HCFA and may be followed by a reaccretion.
17	28	Informs the State that a beneficiary was deleted from the TPM files because another State submitted an accretion accepted by TPS.
17	51	Informs the State that a State-submitted deletion action posted to the TPM. The deletion occurred because the individual is no longer a member of the State's coverage group.
17	53	Informs the State that a State-submitted deletion action posted to the TPM. The deletion occurred because the individual is deceased. The effective date must be the month and year of death.
17	59	Informs the State that HCFA performed a clerical deletion prompted by a written request from the State or by a HCFA-1957 submitted by an SSO.
17	72	Informs the State that a closed period of coverage prior to existing coverage was added to the TPM.
17	76	Informs the State that a closed period of buy-in coverage was established as requested by the State.
20	XX	Informs the State that a deletion action it submitted was rejected either because there is no record of on-going buy-in coverage under the HIB, or because jurisdiction rests with another State.
20	51	Informs the State that a deletion action submitted by the State was rejected because there is no record of buy-in coverage under the HIB submitted, or because another State has jurisdiction.

(Continued)

Code	Code	Description
20	53	Informs the State that a deletion action submitted by the State was rejected because there is no record of buy-in coverage under the HIB submitted or because another State has jurisdiction.
20	76	Informs the State that the deletion portion of a simultaneous accretion/deletion action was rejected because the HIB claim number in the accretion failed to match a record on the EDB.
21	XX	Informs the State that the attempted accretion cannot be matched to the Health Insurance Master record or to the MBR. Each code 21 contains an alphabetic sub code in position 51.
21	61	Informs the State that the submitted accretion action was rejected because the accretion cannot be matched to the EDB.
21	75	Informs the State the accretion portion of a simultaneous accretion/deletion action was rejected because the claim number in the accretion cannot be matched to a Health Insurance Master record. Companion code = 76.
23	XX	Informs the State that the claim number or BIC changed. A code 23 may be applied to an accretion, deletion, State change record, or an ongoing code 41 or code 91 transaction.
23	bb	Informs the State that a claim number change processed to an ongoing buy-in record (code 41).
23	51	Deletion code claim number change.
23	53	Deletion code claim number change.
23	61	Accretion code claim number change.
23	76	Deletion code claim number change.
23	75	Deletion code claim number change.
23	62	Accretion code claim number change.
23	99	Informs the State that the claim number on a State-submitted change record changed to conform to HCFA/SSA master records.
24	XX	Informs the State that the submitted accretion or deletion action was rejected because the effective date was in error. An accretion is rejected if the effective date is beyond the Billing month.
24	51	Deletion code rejects.
24	53	Deletion code rejects.
24	61	Accretion reject codes.
24	75	Accretion reject codes.
24	76	Deletion code rejects.
25	XX	Informs the State that the accretion or deletion action was rejected because it duplicates a transaction previously processed by the Third Party System. The code 25XX reject contains an alphabetic subcode.
25	51	Deletion reject codes.

(Continued)

Code	Code	Description
25	53	Deletion reject codes.
25	61	Accretion reject codes.
27	XX	Informs the State that the submitted accretion or deletion action was rejected because the transaction contained an invalid code (such as blank, alphabetic, or invalid numeric combination).
27	51	Informs the State that the deletion record submitted was rejected.
27	53	Informs the State that the deletion record submitted was rejected.
27	61	Informs the State that the accretion record submitted was rejected.
27	75	Informs the State that a code 75 accretion submitted by the State was rejected because it was not followed by a code 76 deletion.
27	76	Informs the State that a code 76 deletion submitted by the State was rejected because it was not preceded by a code 75 accretion.
28	XX	Informs the State that the simultaneous accretion/deletion action was rejected because the period of coverage requested is entirely within Buy-In coverage period already established on the TPM.
28	75	If the requested period of Buy-In coverage is contained in a prior closed history field on the TPM, position 51 contains a P. If the period is in the current history field, position 51 is blank.
28	76	If the requested period of Buy-In coverage is contained in a prior closed history field on the TPM, position 51 contains a P. If the period is in the current history field, position 51 is blank.
29	XX	Informs the State that the accretion or simultaneous accrete/delete was rejected because there is a death deletion on the TPM. Subcode D indicates the State-submitted the deletion. E indicates MBR.
29	61	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
29	75	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
29	76	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
30	XX	Informs the State that the effective date in the accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date. The Third Party System creates two records.
30	61	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.

(Continued)

Code	Code	Description
30	75	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.
31	XX	The accretion or deletion submitted by the State cannot be processed in the month of submittal. This interim reply is controlled by the State until a definitive response is received from HCFA.
31	51	Informs the State that the definitive reply to a State-submitted deletion is delayed for one month because the deletion encountered a cross-reference record on the TPM.
31	53	Informs the State that the definitive reply to a State-submitted deletion is delayed for one month because the deletion encountered a cross-reference record on the TPM.
31	61	Informs the State that the definitive reply to a State-submitted accretion is delayed because the claim number in the accretion failed to match a corresponding record on the Health Insurance Master record.
32	XX	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	61	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	75	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	76	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
41	bb	Informs the State that the individual is on the State's payroll as an ongoing item. The State is responsible for paying the individual's Part B premium and has deletion responsibility.
42	XX	Represents a credit adjustment of premium liability for the State. This is a result of adjusting either the Buy-In accretion effective date or the deletion effective date of an existing TPM master record.
42	bb	Credit adjustment to the State because the duplicate master records were identified. The duplicate Billing occurred for one or more months of Buy-In coverage. The duplicate premiums are refunded to the State.
42	11	Adjustment of the Buy-In accretion date in an on-going record to a later date. This was necessary because the Third Party System was notified of a condition that changed the individual's Medicare entitlement date

(Continued)

Code	Code	Description
42	14	Informs the State that an existing deletion date was adjusted to an earlier date. This was because an HCFA-initiated SSI accretion that has higher priority and overrides an existing deletion.
42	15	Informs the State that an existing deletion date was adjusted to an earlier date because the individual did not meet all the requirements for Medicare and should not have been terminated.
42	16	Informs the State that an existing death deletion date was in error and was adjusted to an earlier date.
42	41	Informs the State that there were duplicate master records on the TPM. At least one of the duplicate records is a code 41 State jurisdiction item. The credit adjustment is for the period of duplicate Buy-In coverage.
42	68	Informs the State that the accretion date on a TPM record was adjusted to a later date, resulting in a credit to the State.
42	69	Informs the State that a deletion date on a TPM record was adjusted to an earlier date, resulting in a credit to the State.
43	XX	Represents a debit adjustment of premium liability for the State. These actions are the result of adjusting either the accretion effective date or the deletion effective date of an existing master on the TPM.
43	68	Informs the State that the accretion date on the TPM record was adjusted to an earlier date, resulting in a debit to the State.
43	69	Informs the State that the deletion date on a TPM record was adjusted to a later date, resulting in a debit to the State.
43	72	This record is always processed in conjunction with the codes 3061 and 1161 and occurs when the accretion date in the initial accretion exceeds 24 months.
49	99	Informs the State that its request to correct the sex or welfare Identification number on a master record was rejected because the claim number or the State agency code did not match a master record on TPM.

Features – Protected – Double-click to open a pop-up window with description of transaction codes and modifier.

Edits – None

To Correct – N/A

Field Name: Mod

Description – Buy-In Part A modifier indicator on the Billing tape. It is the last two numeric characters of the four-position numeric code.

Format – Two numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Effective Date

Description – Effective date for the transaction on the Buy-In Part A Billing tape

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edits – None

To Correct – N/a

Field Name: Premium Amt

Description – Premium amount on the Billing record. On an accretion acknowledgment record, this field reflects a debit for the amount the State owes. On a deletion acknowledgment record, this field reflects any credit due to the State.

Format – Eight numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Next RID No

Description – Opens the Buy-In Coverage window for another member

Format – 12 numeric characters

Features – None

Edit – 91007 – Must be numeric

To Correct – Verify entry. The RID No. must be 12 numeric characters

Edit – 91046 – New key is required.

To Correct – An entry is required in order to search for a member. Key in a valid RID No.

Edit – 4100 – No match found.

To Correct – Enter a valid RID No. There was not a match in the member file for the ID keyed.

Other Edits

None

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYA_BILL

W_RE_ABILL_INFO

W_CDE_BUY_BILL

Data Windows – DW_RE_BUYA_BILL

DW_RE_HEADER

DW_RE_ABILL_INFO

DW_CDE_BUY_BILL

Menu – M_RE_MAINTENANCE

System Features

Save at the bottom of the Buy-In A Billing window saves changes made to the window.

Highlighting a segment and clicking **Select** at the bottom of the page, opens More Buy-In A Information.

Exit closes the window.

Section 4: More Buy-In A Information Window

Introduction

This window contains the remaining fields from a Buy-In Part A HCFA transaction, when the Billing transaction fields did not match the member HIB, last name, first name, and date of birth in the Indiana*AIM* system. It is mostly used for new accretions and is only available when a **Y** appears in the More Buy-In field located on the Medicare Part A Billing window.

Figure 4.1 – More Buy-In A Information Window

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member.

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle intial

Format – 29 alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Sex

Description – Member's sex according to HCFA

Format – One alphabetic character

Features – Protected

Edits – None

To Correct – N/a

Field Name: Birth Date

Description – Member's date of birth according to HCFA

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edits – None

To Correct – N/a

Field Name: New HIB

Description – Member's new Medicare ID (HIB) according to HCFA. This only applies to code 23 transactions

Format – 12 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Medicaid ID

Description – Member's State welfare identification number according to HCFA

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYA_BILL

W_RE_ABILL_INFO

W_CDE_BUY_BILL

Data Windows – DW_RE_BUYA_BILL

DW_RE_HEADER

DW_RE_ABILL_INFO

DW_CDE_BUY_BILL

Menu – M_RE_MAINTENANCE

System Features

Exit closes the window.

Section 5: Buy-In B Billing Window

Introduction

IFSSA and EDS use the Buy-In B Billing window to view the transactions sent by HCFA on the Buy-In B Billing Tape. Only certain users have the capability to update the error field on the Buy-In B Billing window, drag records from the Billing B Mismatches window to the Buy-In B Billing window, and save changes.

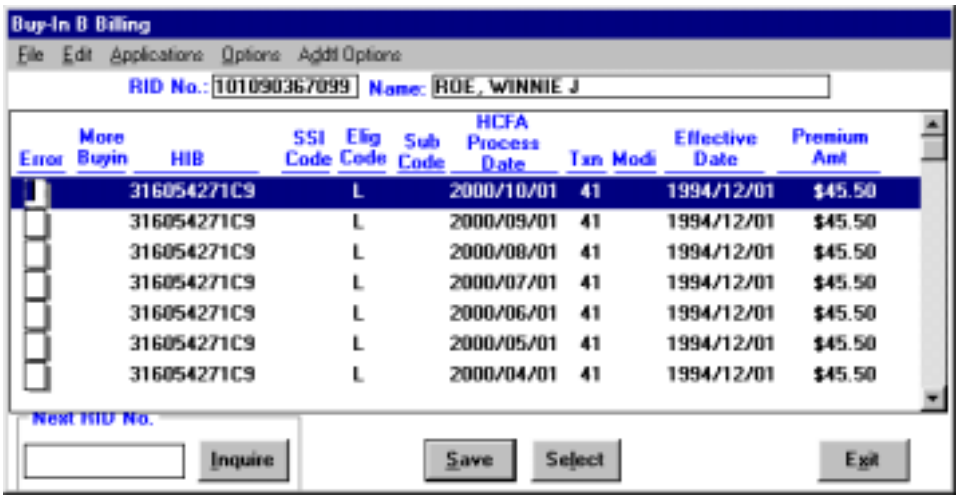

Figure 5.1 – Buy-In B Billing Window

File	Edit	Applications	Options	
Audit	Copy	Adhoc Reporting	**Base**	**Standard**
Print	Paste	Claims	Eligibility	Replacement
Exit	Cut	Financial	Previous	
Exit Indiana*AIM*		Managed Care	LOC	Name
		MARS	Patient Liab	PCNs
	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift +Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 5.2 - Buy-In B Billing Menu Tree

Figure 5.2 is an illustration of the menu tree for the Buy-In B Billing window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Buy-In B Billing window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, **Options**, and **Addtl Options** have the same functions in all the member windows.

Menu Selection: File

These commands print the window, delete, exit the Buy-In B Billing window and exit Indiana*AIM*.

Audit – Audits changes to the window

Print – Prints the window

Exit – Exits the window

*Exit Indiana*AIM – Exits from Indiana*AIM*

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURs – Access the Third Party Liability windows.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial.

Format – 29 alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Error

Description – Updated by the user to indicate whether the Billing record applied to the wrong member.

Format – One alphabetic character

Features – None

Edits – 91026 - Data must be **Y** or **N**

To Correct – Verify entry, data must be either **Y** or an **N**

Field Name: More Buy-In

Description – Indicates if there is more Buy-In Billing information kept on file because of a mismatch between HCFA and the Indiana*AIM*.

Format – One- alphabetic character

Features – Protected - Double-click to open a pop-up window with more Buy-In B information for the member when the More Buy-In is **Y**.

Edits – 91026 - Data must be **Y** or **N**

To Correct – Verify entry, data must be either a **Y** or an **N**

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: SSI Code

Description – One- alphabetic character code describing the beneficiary's Social Security Income (SSI) status.

Format – One-character alphabetic

Features – Protected

Edits – None

To Correct – N/a

Field Name: Elig Code

Description – Buy-In eligibility code received on the Buy-In Part B Billing tape that describes the reason the member is eligible for Buy-In.

Format – One-character alphabetic

Features – Protected

Edits – None

To Correct – N/a

Field Name: Sub Code

Description – Applicable to a rejected accretion record (code 21xx), a duplicate accretion, or deletion record (25xx), or a State-submitted accretion record that matches a death deletion (code29xx)

Format – One alphabetic character

Features – Protected

Edits – None

To Correct – N/a

Field Name: HCFA Process Date

Description – Date the Buy-In Part B Billing tape processed.

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edits – None

To Correct – N/a

Field Name: Txn

Description –Buy-In Part B transaction code. It is the first two characters of the four-character numeric code. This code represents either a response to a transaction the State sent or a transaction initiated by HCFA.

Format – Two numeric characters

Valid values:

Code	Code	Description
11	XX	Informs the State that the individual was accreted to Medicare, which results in a debit action to the State. The State is liable for the individual's premium and is billed monthly.
11	25	Inform the State that the effective date in an accretion submission was adjusted by the Third Party System to show a later date. The TPM showed a closed coverage period for a different State.
11	28	Inform the State that the effective date in an accretion submission was adjusted by the Third Party System to show a later date. The TPM showed a closed coverage period for a different State.
11	61	Informs the State that the individual accreted to Medicare. The effective date is the same as reported, except when a code 30 is present.
11	65	Informs the State that an accretion processed to the TPM by HCFA. The action occurred because the State identified the person as a QMB.
11	67	Informs the State that a Public Welfare (PW) accretion processed to the TPM. The State has four months following the month it received notification to request an annulment or termination of the Buy-In action.

(Continued)

Code	Code	Description
11	72	Informs the State that a closed period of buy-in coverage, which is prior to existing Buy-In coverage, was added to the TPM.
11	75	Informs the State a simultaneous accretion (1175)/deletion (1776) action was added to the TPM. The deletion date is more than two months prior to the update month.
11	80	Informs the State that HCFA has created a buy-in record on the TPM for an SSI member. The effective date is the first month of Buy-In elig based on SSI or a Federally admininistered State sup.
11	84	Informs the State that an accretion, which is usually submitted by an alert State in response to a code 86-accretion alert record, was added to the TPM.
11	85	Informs the State that HCFA accreted a Buy-In record to the TPM based on the member's entitlement to SSI. The TPM adjusted the accretion date to the first month after the deletion date of the closed period
11	90	Informs the State that Buy-In responsibility is transferred from HCFA to the State because SSI benefits terminated, but Medicaid eligibility may or will continue.
16	bb	Informs the State that according to SSA's records, the individual is dead and was deleted from the State's buy-in account. To reaccrete, the State must obtain corroboration in writing from SSO.
17	XX	Informs the State that the individual was deleted from Medicare, which triggers a credit action to the State. The premium ends with the month in which the deletion is effective.
17	50	Informs the State that a State-submitted deletion action posted to the TPM. The deletion occurred because the State received notification of a code 1165 accretion.
17	51	Informs the State that a State-submitted deletion action posted to the TPM. The deletion occurred because the individual is no longer a member of the State's coverage group.
17	53	Informs the State that a State-submitted deletion action posted to the TPM. The deletion occurred because the individual is deceased. The effective date must be the month and year of death.
17	81	Informs the State that a State-submitted deletion action posted to the TPM. The deletion occurred because the member was terminated on the State's SDX file for at least three update cycles.
17	28	Informs the State that an individual was deleted from the State's Buy-In account because another State requested that the individual be accreted to its account or because SSI records show a state of residence change.
17	59	Informs the State that a deletion processed to the TPM by a clerical action in the PM. This action was prompted by a State-submitted paper document or an HCFA-1957 submitted by a Social Security office.

(Continued)

Code	Code	Description
17	72	Informs the State that a closed period of Buy-In coverage, which is prior to existing coverage, was added to the TPM. This is always paired with a code 1172 accretion record.
17	76	Informs the State that a closed period of Buy-In coverage was established as requested by the State. The State always receives a code 1175 with the related code 1776.
17	87	Informs the State that HCFA deleted the individual. from the State's Buy-In account after notification by SSA that the individual's SSI entitlement terminated. The SSI status code field contains the termination reason.
18	XX	Informs the State that although there is no evidence of Medicare entitlement, a claim for Medicare is under development by Social Security.
18	61	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is under development.
18	62	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is under development.
18	63	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is under development.
18	64	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is under development.
18	84	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is under development.
19	XX	Informs the State that the individual's application for Medicare was denied. If the system can determine the earliest future date of entitlement to Medicare, the date is furnished.
19	61	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for more details.
19	62	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for a more detailed explanation.
19	63	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for a more detailed explanation.

(Continued)

Code	Code	Description
19	64	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for a more detailed explanation.
19	84	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for a more detailed explanation.
20	50	Informs the State that a deletion action submitted by the State was rejected because there is no record of buy-in coverage under the HIB number submitted or because another State has jurisdiction.
20	81	Informs the State that a deletion action submitted by the State was rejected because there is no record of buy-in coverage under the HIB number or because another State has jurisdiction.
20	76	Informs the State that the deletion portion of a simultaneous accretion/deletion action was rejected because the claim number in the accretion failed to match a Health Insurance Master record.
21	62	Informs the State that the submitted accretion action was rejected because the accretion cannot be matched to a Health Insurance Master record or to the MBR.
21	63	Informs the State that the submitted accretion action was rejected because the accretion cannot be matched to a Health Insurance Master record or to the MBR.
21	64	Informs the State that the submitted accretion action was rejected because the accretion cannot be matched to a Health Insurance Master record or to the MBR.
21	84	Informs the State that the submitted accretion action was rejected because the accretion cannot be matched to a Health Insurance Master record or to the MBR.
21	75	Informs the State the accretion portion of a simultaneous accretion/deletion action was rejected because the claim number in the accretion cannot be matched to a Health Insurance Master record. Companion code = 76.
22	XX	Informs the State that an accretion action was rejected because the item does not match the Health Insurance Master record but does match an MBR on which the individual is receiving disability benefits.
22	61	Accretion reject code.
22	62	Accretion reject code.
22	63	Accretion reject code.
22	64	Accretion reject code.
22	84	Accretion reject code.

(Continued)

Code	Code	Description
23	XX	Informs the State that the claim number or BIC changed. A code 23 may be applied to an accretion, deletion, State change record, or to an ongoing code 41 or code 91 transaction.
23	bb	Informs the State that a claim number change processed to an ongoing buy-in record (code 41 or 91).
23	50	Deletion code claim number change.
23	51	Deletion code claim number change.
23	53	Deletion code claim number change.
23	76	Deletion code claim number change.
23	81	Deletion code claim number change.
23	61	Accretion code claim number change.
23	62	Accretion code claim number change.
23	63	Accretion code claim number change.
23	64	Accretion code claim number change.
23	75	Accretion code claim number change.
23	84	Accretion code claim number change.
23	99	Informs the State that the claim number on a State-submitted change record changed to conform to HCFA/SSA master records.
24	XX	Informs the State that the submitted accretion or deletion action was rejected because the effective date was in error. An accretion is rejected if the effective date is beyond the Billing month.
24	50	Deletion code rejects.
24	51	Deletion code rejects.
24	53	Deletion code rejects.
24	76	Deletion code rejects.
24	81	Deletion code rejects.
24	61	Accretion reject codes.
24	62	Accretion reject codes.
24	63	Accretion reject codes.
24	64	Accretion reject codes.
24	75	Accretion reject codes.
24	84	Accretion reject codes.
25	XX	Informs the State that the accretion or deletion action was rejected because it duplicates a transaction previously processed by the Third Party System. The code 25XX reject contains an alphabetic subcode.
25	50	Deletion reject codes.

(Continued)

Code	Code	Description
25	51	Deletion reject codes.
25	53	Deletion reject codes.
25	81	Deletion reject codes.
25	61	Accretion reject codes.
25	62	Accretion reject codes.
25	63	Accretion reject codes.
25	64	Accretion reject codes.
25	84	Accretion reject codes.
27	XX	Informs the State that the submitted accretion or deletion action was rejected because the transaction contained an invalid code (such as blank, alphabetic, or invalid numeric combination).
27	50	Informs the State that the deletion action was rejected because it was not submitted within the two-month time period allowed or because the Buy-In accretion did not result from a code 1165 action.
27	75	Informs the State that a code 75 accretion submitted by the State was rejected because it was not followed by a code 76 deletion.
27	76	Informs the State that a code 76 deletion submitted by the State was rejected because it was not preceded by a code 75 accretion.
28	XX	Informs the State that the simultaneous accretion/deletion action was rejected because the period of coverage requested is entirely within a Buy-In coverage period already established on the TPM.
28	75	If the requested period of Buy-In coverage is contained in a prior closed history field on the TPM, position 51 contains a P. If the period is in the current history field, position 51 is blank.
28	76	If the requested period of Buy-In coverage is contained in a prior closed history field on the TPM, position 51 contains a P. If the period is in the current history field, position 51 is blank.
29	XX	Informs the State that the accretion or simultaneous accrete/delete was rejected because there is a death deletion on the TPM. Subcode D indicates the State submitted the deletion. E indicates MBR.
29	61	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
29	62	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
29	63	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
29	64	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.

(Continued)

Code	Code	Description
29	75	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
29	76	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
29	84	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.
30	XX	Informs the State that the effective date in the accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date. The Third Party System creates two records.
30	61	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.
30	62	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.
30	63	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.
30	64	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.
30	75	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.
30	84	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to the individual's Medicare entitlement date.
31	XX	The accretion or deletion submitted by the State cannot be processed in the month of submittal. This interim reply is controlled by the State until a definitive response is received from HCFA.
31	50	Informs the State that the definitive reply to a State-submitted deletion is delayed for one month because the deletion encountered a cross-reference record on the TPM.
31	51	Informs the State that the definitive reply to a State-submitted deletion is delayed for one month because the deletion encountered a cross-reference record on the TPM.
31	53	Informs the State that the definitive reply to a State-submitted deletion is delayed for one month because the deletion encountered a cross-reference record on the TPM.

(Continued)

Code	Code	Description
31	61	Informs the State that the definitive reply to a State-submitted accretion is delayed because the claim number in the accretion failed to match a corresponding record on the Health Insurance Master record.
31	62	Informs the State that the definitive reply to a State-submitted accretion is delayed because the claim number in the accretion failed to match a corresponding record on the Health Insurance Master record.
31	63	Informs the State that the definitive reply to a State-submitted accretion is delayed because the claim number in the accretion failed to match a corresponding record on the Health Insurance Master record.
31	64	Informs the State that the definitive reply to a State-submitted accretion is delayed because the claim number in the accretion failed to match a corresponding record on the Health Insurance Master record.
31	84	Informs the State that the definitive reply to a State-submitted accretion is delayed because the claim number in the accretion failed to match a corresponding record on the Health Insurance Master record.
32	XX	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	61	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	62	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	63	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage in prior to existing coverage in TPM current history.
32	64	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	75	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	76	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
32	84	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.
33	XX	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.

(Continued)

Code	Code	Description
33	61	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.
33	62	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.
33	63	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.
33	64	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.
33	84	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.
34	XX	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.
34	50	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.
34	51	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.
34	53	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.
36	62	Informs the State that the accretion in which the claim number and personal characteristics had been verified by the Social Security office was rejected because the item did not match the Health Insurance Master record or MBR
41	bb	Informs the State that the individual is on the State's payroll as an ongoing item. The State is responsible for paying the individual's Part B premium and has deletion responsibility.
42	XX	Represents a credit adjustment of premium liability for the State. This is a result of adjusting either the Buy-In accretion effective date or the deletion effective date of an existing TPM master record.
42	bb	Represents a credit adjustment to the State because the duplicate master records were identified. The duplicate Billing occurred for one or more months of Buy-In coverage. The duplicate premiums are being refunded to the State.
42	11	Adjustment of the Buy-In accretion date in an on-going record to a later date. This was necessary because the Third Party System was notified of a condition that changed the individual's Medicare entitlement date
42	14	Informs the State that an existing deletion date was adjusted to an earlier date. This was due to a HCFA initiated SSI accretion that has higher priority and overrides an existing deletion.
42	15	Informs the State that an existing deletion date was adjusted to an earlier date because the individual did not meet all the requirements for Medicare and should not have been terminated.
42	16	Informs the State that an existing death deletion date was in error and was adjusted to an earlier date.

(Continued)

Code	Code	Description
42	41	Informs the State that there were duplicate master records on the TPM. At least one of the duplicate records is a code 41 State jurisdiction item. The credit adjustment is for the period of duplicate Buy-In coverage.
42	67	The Buy-In effective date of a PW accretion was adjusted to a later date, resulting in a credit to the State.
42	68	Informs the State that the accretion date on a TPM record was adjusted to a later date, resulting in a credit to the State.
42	69	Informs the State that a deletion date on a TPM record was adjusted to an earlier date, resulting in a credit to the State.
42	91	Informs the State that there were duplicate master records on the TPM. At least one of the duplicate records is a code 91 on-going SSI item. The credit adjustment is for the period of duplicate Buy-In coverage.
43	XX	Represents a debit adjustment of premium liability for the State. These actions are the result of adjusting either the accretion effective date or the deletion effective date of an existing master on the TPM.
43	69	Informs the State that the deletion date on a TPM record was adjusted to a later date, resulting in a debit to the State.
49	99	Informs the State that a request to correct the sex code, Buy-In eligibility code, or a welfare ID number on a master record was rejected because the claim number or State agency code in the code 99 did not match a TPM
43	68	Informs the State that the accretion date on a TPM record was adjusted to an earlier date, resulting in a debit to the State.
86	bb	Informs the alert State that an individual in its jurisdiction is entitled to SSI benefits and may be eligible for Buy-In. The individual's SSI and Medicare entitlement dates are contained in the record.
87	bb	Informs the alert State that SSI entitlement terminated for an individual who is on the Buy-In rolls as a code 41.
91	bb	Informs the accrete State that the individual is on the State's Buy-In rolls as an ongoing item. The State is responsible for paying the individual's Part B premium. HCFA has primary deletion responsibility.

Features – Protected – Double-click to open a pop-up window with description of transaction codes.

Edits – None

To Correct – N/a

Field Name: Modi

Description – Buy-In Part B modifier indicator on the Billing tape. It is the last two numeric characters of the four-position numeric code.

Format – Two numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Effective Date

Description – Effective date for the transaction on the Buy-In Part B Billing tape

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edits – None

To Correct – N/a

Field Name: Premium Amt

Description – Premium amount on the Billing record. On an accretion acknowledgment record, this field reflects a debit that is the amount the State owes. On a deletion acknowledgment record, this field reflects any credit due to the State,

Format – Eight numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Next RID No

Description – Opens the Buy-In Coverage window for another member.

Format – 12 numeric characters

Features – None

Edit – 91007 – Must be numeric

To Correct – Verify entry. The RID No. must be 12 numeric characters.

Edit – 91046 – New key is required.

To Correct – An entry is required in order to search for a member. Key in a valid RID No.

Edit – 4100 – No match found.

To Correct – Enter a valid RID No. There was not a match in the member file for the ID keyed.

Other Edits

None

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYB_BILL

W_RE_BBILL_INFO

W_CDE_BUY_BILL

Data Windows – DW_RE_BUYB_BILL

DW_RE_HEADER

DW_RE_BBILL_INFO

DW_CDE_BUY_BILL

Menu – M_RE_MAINTENANCE

System Features

Save at the bottom of the Buy-In B Billing window saves changes make to the window. Highlighting a segment and clicking **Select** at the bottom of the page accesses the More Buy-In B Information. However, unless there is a **Y** in the More Buy-In field, there is no data to view.

Exit closes the window.

Section 6: More Buy-In B Information Window

Introduction

This window contains the remaining fields from a Buy-In Part B HCFA transaction where the Billing transaction fields did not match the member HIB, last name, first name, and date of birth on the Indiana*AIM* system, or when adding new data from the Mismatch Report.

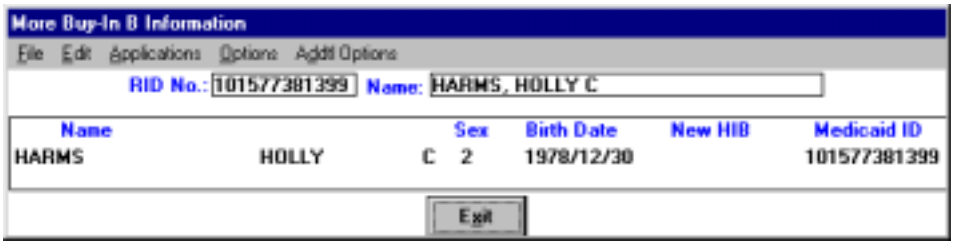

Figure 6.1 – More Buy-In B Information Window

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member.

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial.

Format – 29 alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Sex

Description – Member's sex according to HCFA

Format – One alphabetic character

Features – Protected

Edits – None

To Correct – N/a

Field Name: Birth Date

Description – Member's date of birth according to HCFA

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edits – None

To Correct – N/a

Field Name: New HIB

Description – Member's new Medicare ID (HIB) according to HCFA. This only applies to code 23 transactions.

Format – 12 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Medicaid ID

Description – Member's State identification number according to HCFA

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYB_BILL

W_RE_BBILL_INFO

W_CDE_BUY_BILL

Data Windows – DW_RE_BUYB_BILL

DW_RE_HEADER

DW_RE_BBILL_INFO

DW_CDE_BUY_BILL

Menu – M_RE_MAINTENANCE

System Features

Exit at the bottom of the window closes the More Buy-In Information window.

Section 7: Buy-In Billing Transaction Codes Window

Introduction

This window contains the Buy-In Billing Transaction Codes that HCFA sends to the State through the monthly Buy-In Billing Tapes. Access this window by clicking twice on the transaction code field on the Buy-In Billing window.

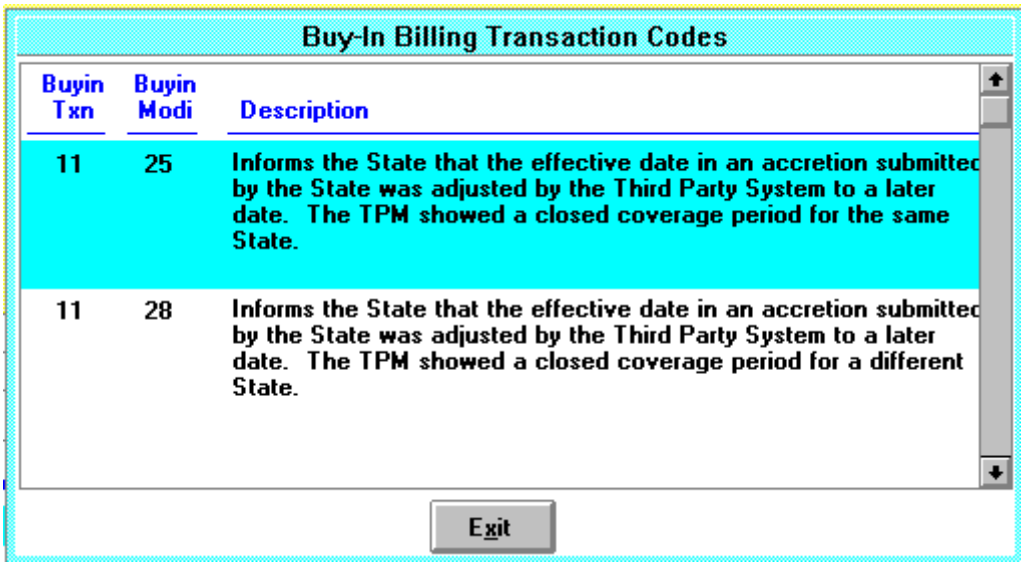

Figure 7.1 – Buy-In Billing Transaction Codes Window

Field Information

Field Name: Buy-In Txn

Description – Buy-In Txn field contains the first two positions of the Buy-In Billing Transaction code. This part provides HCFA's response to the State's record or an action initiated by HCFA.

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Buy-In Modi

Description – Buy-In Modi field contains the last two positions of the monthly Buy-In Billing transaction code from HCFA. This is usually the same transaction code present on the State premium record.

Format – Two numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: Description

Description – Description of the Buy-In Billing transaction code

Format – 200 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYB_BILL

W_RE_BBILL_INFO

W_CDE_BUY_BILL

Data Windows – DW_RE_BUYB_BILL

DW_RE_HEADER

DW_RE_BBILL_INFO

DW_CDE_BUY_BILL

Menu – M_RE_MAINTENANCE

System Features

To select a code, highlight the row and double-click or highlight the row and click **Select**. After double-clicking a row or clicking **Select** the window closes and the selected value is placed in the Txn code field of the Buy-In Premium 150 window.

Exit closes the window.

Section 8: Buy-In Premium 150 Window

Introduction

This window contains the monthly accrete, delete, and change transactions sent to HCFA. Only certain users have the capability to update the Buy-In Premium manually. However, the ICES update may generate an update to the Buy-In Premium 150. When ICES sends new Medicaid or Medicare eligibility information for a member, an action may be created on the Premium 150 tape. Also, the Buy-In Premium 150 may be updated by sending a response to a transaction from the HCFA Billing.

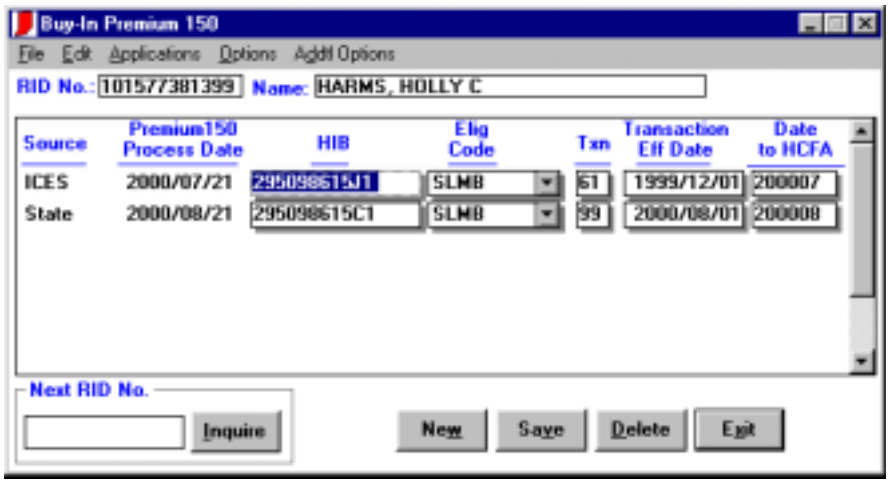

Figure 8.1 – Buy-In Premium 150 Window

File	Edit	Applications	Options	
Print	Copy	Adhoc Reporting	**Base**	**Standard**
Delete	Paste	Claims	Eligibility	Replacement
Exit	Cut	Financial	Previous	
Exit Indiana*AIM*		Managed Care	LOC	Name
		MARS	Patient Liab	PCNs
	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift +Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 8.2 - Buy-In Premium 150 Menu Tree

Figure 8.2 is an illustration of the menu tree for the Buy-In Premium 150 window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Buy-In Premium 150 window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections File, Edit and Applications have the same functions in all the member windows.

Menu Selection: File

These commands print the window, delete, exit the Buy-In Premium 150 window and exit Indiana*AIM*.

Print – Prints the window.

Delete – Allows the user to delete as long as the data has not yet been processed.

Exit – Exits the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy– Copies text for transfer to another area or application.

Paste– Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURs – Accesses the SURs information

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial.

Format – 29 alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Source

Description – Source of the transaction, created by the ICES update process, a reaction to a transaction from the HCFA Billing, or a manual entry by the State.

Format – One alphabetic character

Valid values:

- I – ICES
- S – State
- H – HCFA

Features – Protected – Defaults to State when user adds or changes data.

Edit – None

To Correct – N/a

Field Name: Premium 150 Process Date

Description – Date the Buy-In Part B Premium tape processed.

Format – Eight numeric characters (CCYYMMDD)

Features – Protected – Defaults to zeroes when user adds data

Edit – None

To Correct – N/a

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Updatable

Edit – 4025 – Invalid HIB!

To Correct – Verify keying. The HIB entered is not valid. Refer to the Buy-In Manual for valid HIB number format.

Edit – 4176 – Keyed HIB does not match current HIB. Continue?

To Correct – Verify keying. If the HIB keyed is a new HIB and the user wants it to become the current HIB, continue. If what was keyed is incorrect, try again.

Field Name: Elig Code

Description – Member's eligibility code according to HCFA. This identifies the type of aid category the member is enrolled in.

Format – 15 alphabetic characters

Valid values:

- Money Grant
- Non Money Grant
- QI
- QMB
- SLMB.

Features: Click **Field** to open drop-down list of valid values.

Edit – None

To Correct – N/a

Field Name: Txn

Description – Two-digit transaction code that identifies the necessary by HCFA. The primary transaction codes used by the State are 61 accrete, 51 delete, 53 death delete, and 99 change.

Format – Two numeric characters

Valid values:

Code	Description
50	Deletion code used by the State against a code 1165 accretion posted to the State's Buy-In account by a clerical action in the TPM. Code 50 may be used to annul Buy-In coverage or to enter a termination date
51	Deletion code used by the State to delete an individual from the State's Buy-In account because the individual is no longer a member of the State's coverage group. This code is not used for death deletes.
53	Deletion code used by the State to delete an individual from the State's Buy-In account because the individual is deceased. The effective date of the deletion must be the month and year of death.
61	Used by the State to accrete an individual to the State's Buy-In account. It is used for individuals for whom the State has accretion responsibility.
62	Used only for an item that previously was submitted as a code 61 accretion and was rejected by the Third Party System as a code 2161 because it did not match a Health Insurance Master record.
63	Used by the State to identify accretion records for subsequent State analysis. The code 63 is processed in exactly the same manner as the code 61.
64	Optional accretion code restricted to auto-accrete States. It is used to accrete an individual who appeared on the State's SDX file for three cycles but accreted to Buy-In through SSA/HCFA exchange.
75	Used by the State as the accretion portion of a simultaneous accretion/deletion action to establish a closed period of Buy-In coverage for an individual. Must be paired with a code 76-deletion record.
76	Used by the State as the deletion portion of a simultaneous accretion/deletion action to establish a closed period of Buy-In coverage for an individual. The code must be paired with a code 75 accretion record
81	Optional deletion code restricted to auto-accrete States. Used to delete an individual from Buy-In who was terminated on the State's SDX file for at least three cycles but not deleted through SSA/HCFA

(Continued)

Code	Description
84	Used by alert States to accrete an individual to the Buy-In account following the receipt of a code 86 SSI accretion alert record. The code 84 is processed in exactly the same manner as the code 61.
99	Used by the State to correct the sex code, the Buy-In eligibility code, or the welfare identification number on an existing Buy-In record on the TPM.

Features – Double-click to open a pop-up window with valid transaction codes. Select transaction code from pop-up window if desired.

Edit – 91006 – Field is required!

To Correct – A transaction code is required. Please key a valid transaction code.

Edit – 91011 – Record not found - please try again!

To Correct – The transaction code entered is not valid. Please key a valid transaction code.

Field Name: Transaction Eff Date

Description – Effective date on the Buy-In Part B Premium Tape.

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Field Name: Date to HCFA

Description – Effective date sent to HCFA

Format – Six numeric characters (CCYYMM)

Features – None

Edit – None

To Correct – N/a

Field Name: Next RID No

Description – Opens the Buy-In Coverage window for another member.

Format – 12 numeric characters

Features – None

Edit – 91007 – Must be numeric

To Correct – Verify entry. The RID No. must be 12 numeric characters.

Edit – 91046 – New key is required.

To Correct – An entry is required in order to search for a member. Key in a valid RID No.

Edit – 4100 – No match found.

To Correct – Enter a valid RID No. There was not a match in the member file for the ID keyed.

Other Edits

8004 – No changes keyed! Occurs when the user clicks **Save** without making any changes

4175 – Cannot update when Process Date exists. Occurs when the user attempts to delete a row that was already sent on a Premium tape to HCFA.

91102 – Please select a record. Occurs when the user clicks **Delete** without selecting a row

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYB_PREM

W_CDE_BUY_PREM

Data Windows – DW_RE_BUYB_PREM

DW_RE_HEADER

DW_CDE_BUY_PREM

Menu – M_RE_MAINTENANCE

System Features

New at the bottom of the window allows selected users to add a new record to the Buy-In Premium 150.

Save at the bottom of the Buy-In Premium 150 window saves changes made to the window.

Delete deletes a record from the Buy-In Premium 150.

Exit closes the window.

Section 9: Buy-In Premium S15 Window

Introduction

This window contains the monthly accrete, delete, and change transactions sent to HCFA. Only certain users have the capability to update the Buy-In Premium S15 manually. However, the ICES updates may generate an update to the Buy-In Premium S15. When ICES sends new Medicaid or Medicare eligibility information for a member, an action may be created on the Premium S15 tape. Also, the Buy-In Premium S15 may be updated by sending a response to a transaction from the HCFA Billing.

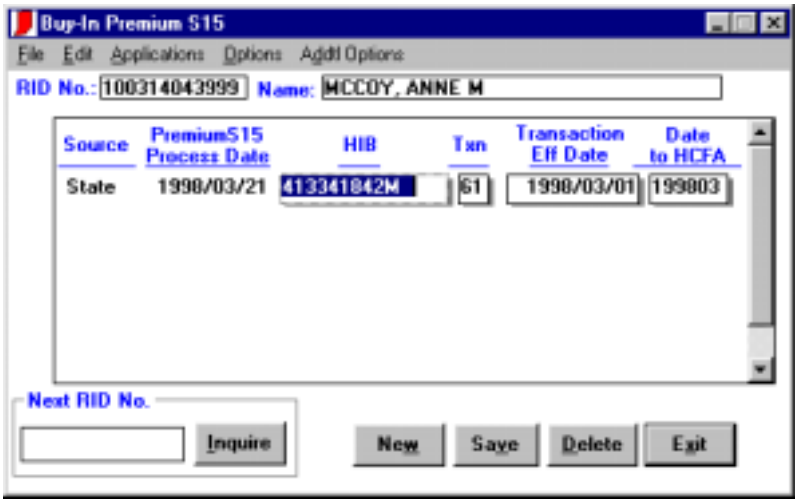

Figure 9.1 – Buy-In Premium S15 Window

File	Edit	Applications	Options	
Print	Copy	Adhoc Reporting	**Base**	**Standard**
Delete	Paste	Claims	Eligibility	Replacement
Exit	Cut	Financial	Previous	
Exit Indiana*AIM*		Managed Care	LOC	Name
		MARS	Patient Liab	PCNs
	Shift+ Del	Prior Authorization	Spenddown	Addresses
	Shift +Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 9.2 - Buy-In Premium S15 Menu Tree

Figure 9.2 is an illustration of the menu tree for the Buy-In Premium S15 window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Buy-In Premium S15 window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections File, Edit and Applications have the same functions in all the member windows.

Menu Selection: File

These commands delete, print the window, exit the Buy-In Premium S15 window and exit Indiana *AIM*.

Print – Prints the window

Delete – Allows the user to delete changes

Exit – Exits the window

*Exit Indiana*AIM – Exits from Indiana*AIM*

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy– Copies text for transfer to another area or application.

Paste– Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURs – Accesses the SURs information.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member.

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial.

Format – 29 alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Source

Description – Source of the transaction, created by the ICES update process, a reaction to a transaction from the HCFA Billing, or a manual entry by the State.

Format – One alphabetic character

Valid values:

- *I* – ICES
- *S* – State
- *H* – HCFA

Features – Protected – Defaults to State when user adds or changes data

Edit – None

To Correct – N/A

Field Name: Premium S15 Process Date

Description – Date the Buy-In Part A Premium tape processed.

Format – Eight numeric characters (CCYYMMDD)

Features – Protected – Defaults to zeroes when user adds data

Edit – None

To Correct – N/a

Field Name: HIB

Description – Member's current Medicare ID

Format – 12-character alphanumeric

Features – Updatable

Edit – 4025 – Invalid HIB!

To Correct – Verify entry. The HIB is not valid. Refer to the Buy-In Manual for valid HIB format

Edit – 4176 – Keyed HIB does not match current HIB. Continue?

To Correct – Verify entry. If the HIB keyed is a new HIB and the user wants it to become the current HIB, continue. If what was keyed is incorrect, try again.

Field Name: Txn

Description – Two-digit transaction code that identifies the necessary action by HCFA. The primary transaction codes used by the State are 61 accrete, 51 delete, 53-death delete, and 99 change.

Format – Two numeric characters

Valid values:

Code	Description
50	Deletion code used by the State against a code 1165 accretion posted to the State's Buy-In account by a clerical action in the TPM. Code 50 may be used to annul Buy-In coverage or to enter a termination date
51	Deletion code used by the State to delete an individual from the State's Buy-In account because the individual is no longer a member of the State's coverage group. This code is not used for death deletes.
53	Deletion code used by the State to delete an individual from the State's Buy-In account because the individual is deceased. The effective date of the deletion must be the month and year of death.
61	Used by the State to accrete an individual to the State's Buy-In account. It is used for individuals for whom the State has accretion responsibility.
62	Used only for an item that previously was submitted as a code 61 accretion and was rejected by the Third Party System as a code 2161 because it did not match a Health Insurance Master record.
63	Used by the State to identify accretion records for subsequent State analysis. The code 63 is processed in exactly the same manner as the code 61.
64	Optional accretion code restricted to auto-accrete States. It is used to accrete an individual who appeared on the State's SDX file for three cycles but accreted to Buy-In through SSA/HCFA exchange.
75	Used by the State as the accretion portion of a simultaneous accretion/deletion action to establish a closed period of Buy-In coverage for an individual. Must be paired with a code 76 deletion record.
76	Used by the State as the deletion portion of a simultaneous accretion/deletion action to establish a closed period of Buy-In coverage for an individual. The code must be paired with a code 75 accretion record
81	Optional deletion code restricted to auto-accrete States. Used to delete an individual from Buy-In who has been terminated on the State's SDX file for at least three cycles but not deleted through SSA/HCFA
84	Used by alert States to accrete an individual to the Buy-In account following the receipt of a code 86 SSI accretion alert record. The code 84 is processed in exactly the same manner as the code 61.
99	Used by the State to correct the sex code, the Buy-In eligibility code, or the welfare identification number on an existing Buy-In record on the TPM.

Features – Double-click to open a pop-up window with valid transaction codes. Select transaction code from pop-up window if desired.

Edit – 91006 – Field is required!

To Correct – A transaction code is required. Please key a valid transaction code.

Edit – 91011 – Record not found – please try again!

To Correct – The transaction code entered is not valid. Please key a valid transaction code.

Field Name: Transaction Eff Date

Description – Effective date on the Buy-In Part A Billing Tape

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91001 – Invalid Date (MMDDCCYY)

To Correct – Verify date (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date (CCYY/MM/DD)

Field Name: Date To HCFA

Description – Effective date sent to HCFA.

Format – Six-character numeric (CCYYMM)

Features – None

Edit – None

To Correct – N/a

Field Name: Next RID No

Description – Opens the Buy-In Coverage window for another member.

Format – 12 numeric characters

Features – None

Edit – 91007 – Must be numeric

To Correct – Verify entry the RID No. must be 12 numeric characters.

Edit – 91046 – New key is required.

To Correct – An entry is required in order to search for a member. Key in a valid RID No.

Edit – 4100 – No match found.

To Correct – Enter a valid RID No. There was not a match in the member file for the ID keyed.

Other Edits

8004 – No changes keyed! Occurs when the user clicks **Save** without making any changes

4175 – Cannot update when Process Date exists. Occurs when the user attempts to delete a row already sent on a Premium tape to HCFA.

91102 – Please select a record. Occurs when the user clicks **Delete** without selecting a row

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYA_PREM

W_CDE_BUY_PREM

Data Windows – DW_RE_BUYA_PREM

DW_RE_HEADER

DW_CDE_BUY_PREM

Menu – M_RE_MAINTENANCE

System Features

New at the bottom of the window allows selected users to add a new record to the Buy-In Premium S15.

Save at the bottom of the Buy-In Premium S15 window saves changes make to the window.

Delete deletes a record from the Buy-In Premium S15.

Exit closes the window.

Section 10: Buy-In Premium Transaction Codes Window

Introduction

This window contains the Buy-In Premium transaction codes sent on the Premium 150 and Premium S15 tapes to HCFA. Refer to *Appendix A* for more information on the Premium transaction codes.

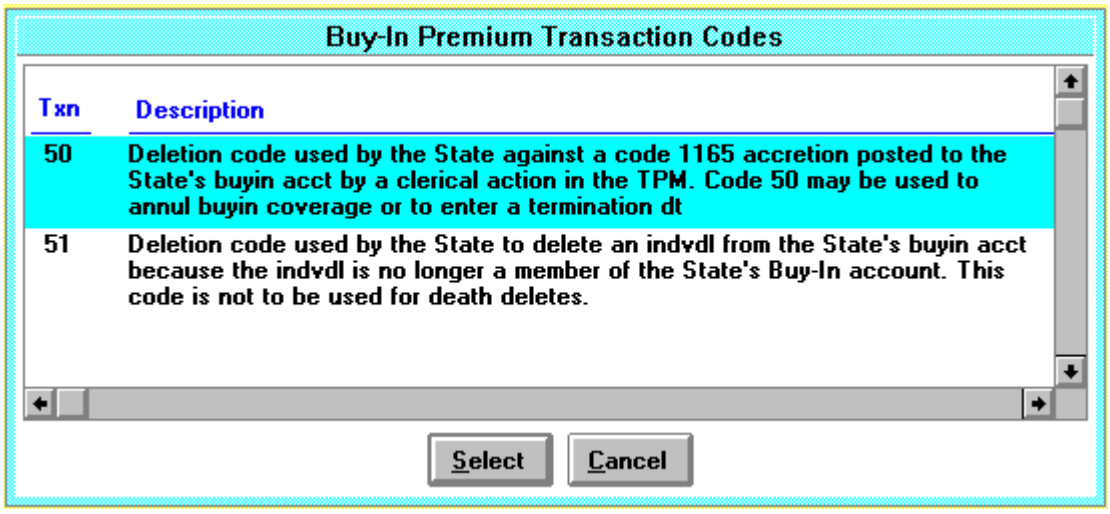

Figure 10.1 – Buy-In Premium Transaction Codes Window

Field Information

Field Name: Txn

Description – Two-digit transaction code that identifies the necessary action by HCFA. The primary transaction codes used by the State are 61 accrete, 51 delete, 53 death delete, and 99 change

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Description

Description – Description of the Buy-In transaction code sent to HCFA on the Premium 150 and Premium S15 tapes.

Format – 200 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYA_PREM

W_CDE_BUY_PREM

Data Windows – DW_RE_BUYA_PREM

DW_RE_HEADER

DW_CDE_BUY_PREM

Menu – M_RE_MAINTENANCE

System Features

To select a code, highlight the row and double-click or highlight the row and click **Select**. After double-clicking a row or clicking **Select,** the window closes and the selected value is placed in the Txn code field of the Buy-In Premium 150 window. Click **Cancel** to exit the window with no selection.

Section 11: Billing A Mismatches Window

Introduction

This window contains the transactions that do not match a member record in Indiana*AIM*. The fields required for a match from HCFA in Indiana*AIM* are Current HIB and Member ID. IFSSA and EDS use the Billing A Mismatches window to update a record where needed and enter the RID to send that record to the Buy-In A Billing window. Only certain users have the capability to update the Billing A Mismatches window.

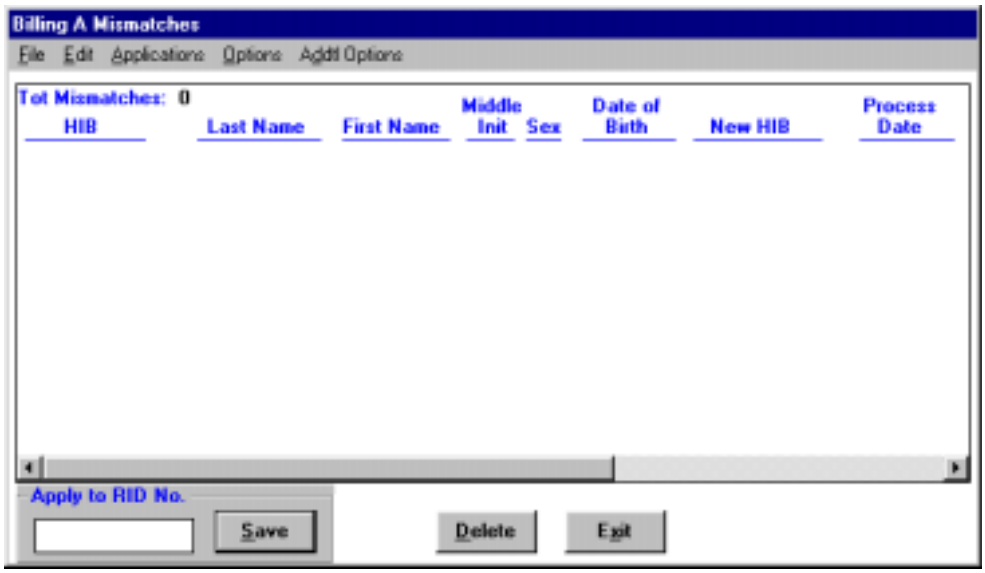

Figure 11.1 – Billing A Mismatches Window

File	Edit	Applications	Options	
Save	Copy	Adhoc Reporting	**Base**	**Standard**
Delete	Paste	Claims	Eligibility	Replacement
Print	Cut	Financial	Previous	
Exit		Managed Care	LOC	Name
Audit		MARS	Patient Liab	PCNs
Exit Indiana*AIM*	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift +Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
			Screenings	Premium 150
			Supplement	Premium S15
			Recip Screenings	Dual Aid Eligibility
			Recip Notices	Billing A Mismatches
			Screening Procedures	Billing B Mismatches
			Immunization Procedures	Billing A Exceptions
			System Parms	Billing B Exceptions

Figure 11.2 - Billing A Mismatches Menu Tree

Figure 11.2 is an illustration of the menu tree for the Billing A Mismatches window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Billing A Mismatches window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit, Applications** and **Options** have the same functions in all the member windows.

Menu Selection: File

These commands save changes made to the Billing A Mismatches window, delete, print the window, exit the Billing A Mismatches window, audit, and exit Indiana*AIM*.

Save – Saves changes made to the window.

Delete – Deletes changes to the window

Print – Prints the window.

Exit – Exits the window.

Audit – Audits changes to the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURs – Accesses the SURs information.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Last Name

Description – Member's last name

Format – 12 alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: First Name

Description – Member's first name

Format – Seven alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Middle Initial

Description – Member's middle initial

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Sex

Description – Member's sex according to HCFA

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Date of Birth

Description – Member's date of birth according to HCFA

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: New HIB

Description – Member's new Medicare ID (HIB) according to HCFA. This only applies to code 23 transactions

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/A

Field Name: Process Date

Description – Date the Buy-In Part A Billing tape was processed by EDS.

Format – Eight numeric characters CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: Txn

Description – Buy-In Billing Tape transaction code. It is the first two characters of the four-character numeric code. This code represents either a response to a transaction the State sent or a transaction initiated by HCFA.

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Modi

Description – Buy-In Billing Tape modifier indicator on the Billing tape. It is the last two numeric characters of the four-position numeric code.

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Sub Code

Description – Applicable to a rejected accretion record (code 21xx), a duplicate accretion, or deletion record (25xx), or a State-submitted accretion record that matches a death deletion (code29xx)

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Effective Date

Description – Effective date for the transaction on the Buy-In Part A Billing tape

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: Medicaid ID

Description – Member's identification number according to HCFA

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Premium Amount

Description – Premium amount on the Billing record. On an accretion acknowledgment record, this field reflects a debit that is the amount the State owes. On a refund acknowledgment record, this field reflects any credit due to the State.

Format – Eight numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Apply To RID No.

Description – Used to key in the RID No to that a highlighted record is supposed to move. The record is moved to the Billing A window

Format – 12 numeric characters

Features – Enter Medicaid ID here to match row to a member

Edit – 91007 – Must be numeric

To Correct – Verify entry. The RID No. must be 12 numeric characters

Edit – 91046 – New key is required.

To Correct – An entry is required in order to search for a member. Key in a valid RID No.

Edit – 4100 – No match found.

To Correct – Enter a valid RID No. There was not a match in the member file for the ID keyed.

Other Edits

91102 – Please select a record. Occurs when user clicks **Save** without selecting a row

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYA_MISMATCH

Data Windows – DW_RE_BUYA_MISMATCH

Menu – M_RE_MAINTENANCE

System Features

The Billing A Mismatches window contains a horizontal scroll bar that allows the user to view the rest of the fields in the window.

Save at the bottom of the window saves changes made to the window.

Delete removes an unwanted entry.

Exit closes the window.

Section 12: Billing B Mismatches Window

Introduction

This window contains the transactions that do not match a member record in Indiana*AIM*. The fields that are required for a match from HCFA in Indiana*AIM* are current or previous HIB, current last name, current first name, and date of birth. IFSSA and EDS use the Billing B Mismatches window to update a record where needed and enter the RID to send that record to the Buy-In B Billing window. Only certain users have the capability to update the Billing B Mismatches window.

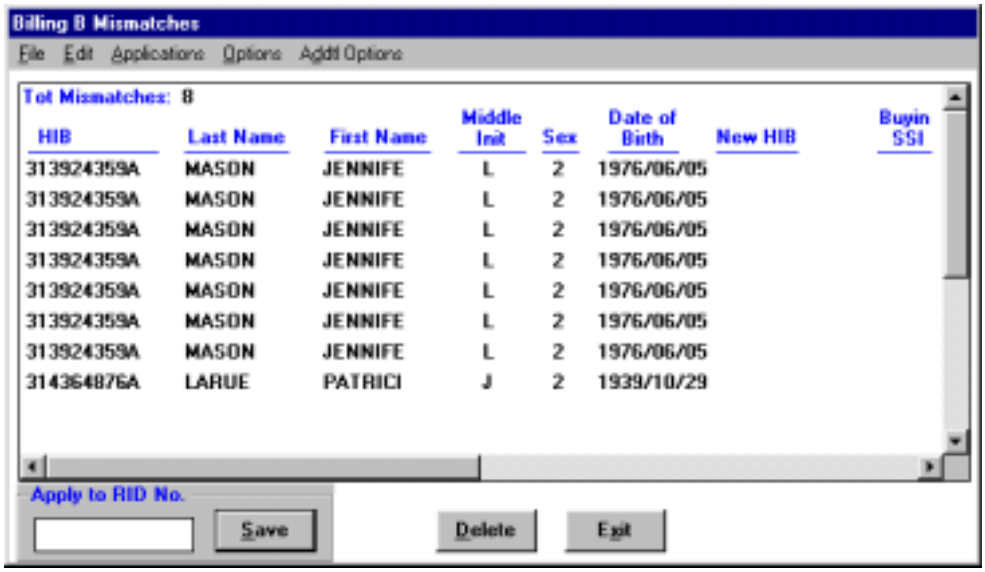

Figure 12.1 – Billing B Mismatches Window

File	Edit	Applications	Options	
Save	Copy	Adhoc Reporting	**Base**	**Standard**
Delete	Paste	Claims	Eligibility	Replacement
Print	Cut	Financial	Previous	
Exit		Managed Care	LOC	Name
Audit		MARS	Patient Liab	PCNs
Exit Indiana*AIM*	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift +Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 12.2 - Billing B Mismatches Menu Tree

Figure 12.2 is an illustration of the menu tree for the Billing B Mismatches window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Billing B Mismatches window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, and **Options** have the same functions in all the member windows.

Menu Selection: File

These commands save changes made to the Billing B Mismatches window, delete, print the window, exit the Billing B Mismatches window, audit any changes and exit Indiana*AIM*.

Save – Saves changes made the window.

Delete – Deletes changes to the window

Print – Prints the window.

Exit – Exits the window.

Audit – Audits changes to the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURS – Accesses the SURs information.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Last Name

Description – Member's last name

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: First Name

Description – Member's first name

Format – Seven alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Middle Initial

Description – Member's middle initial

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Sex

Description – Member's sex according to HCFA

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Date Of Birth

Description – Member's date of birth according to HCFA

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: New HIB

Description – Member's new Medicare ID (HIB) according to HCFA. This only applies to code 23 transactions.

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Buy-In SSI

Description – One-position alphabetic code that describes the member's Social Security Income (SSI) status

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Elig Code

Description – Buy-In eligibility code received on the Buy-In Part B Billing tape that describes the reason the member is eligible for Buy-In.

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Process Date

Description – Date the Buy-In Part B Billing tape was processed.

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: Txn

Description – Buy-In Billing Tape transaction code. It is the first two characters of the four-character numeric code. This code represents either a response to a transaction the State sent or a transaction initiated by HCFA.

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Modi

Description – Buy-In Billing Tape modifier indicator on the Billing tape. It is the last two numeric characters of the four-position numeric code.

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Sub Code

Description – Applicable to a rejected accretion record (code 21xx), a duplicate accretion or deletion record (25xx), or a State-submitted accretion record that matches a death deletion (code29xx)

Format – One alphabetic character

Features – Protected

Edits – None

To Correct – N/a

Field Name: Effective Date

Description – Effective date for the transaction on the Buy-In Part B Billing tape.

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: Medicaid ID

Description – Member's identification number according to HCFA

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Premium Amount

Description – Premium amount on the Billing record. On an accretion acknowledgment record, this field reflects a debit that is the amount the State owes. On a refund acknowledgment record, this field reflects any credit due to the State.

Format – Eight numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Apply To RID No

Description – Used to key in the RID No to that a highlighted record is supposed to move. The record is moved to the Billing B window.

Format – 12 numeric characters

Features – Enter Medicaid ID here to match row to a member

Edit – 91007 – Must be numeric

To Correct – Verify entry. The RID No. must be 12 numeric characters.

Edit – 91046 – New key is required.

To Correct – An entry is required in order to search for a member. Key in a valid RID No.

Edit – 4100 – No match found.

To Correct – Enter a valid RID No. There was not a match in the member file for the ID keyed.

Other Edits

91102 – Please select a record. Occurs when user clicks **Save** without selecting a row

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYB_MISMATCH

Data Windows – DW_RE_BUYB_MISMATCH

Menu – M_RE_MAINTENANCE

System Features

The Billing B Mismatches window contains a horizontal scroll bar that allows the user to view the rest of the fields on the window.

Save saves changes made to the window.

Delete deletes the highlighted item in the window.

Exit closes the window.

Section 13: Dual Aid Category Eligibility Window

Introduction

The Dual Aid Category Eligibility window contains the member's dual aid category. This window applies to the SLIMB and QMB members. If a member has one of these categories in addition to another aid category, the Medicaid eligibility window shows the other aid category.

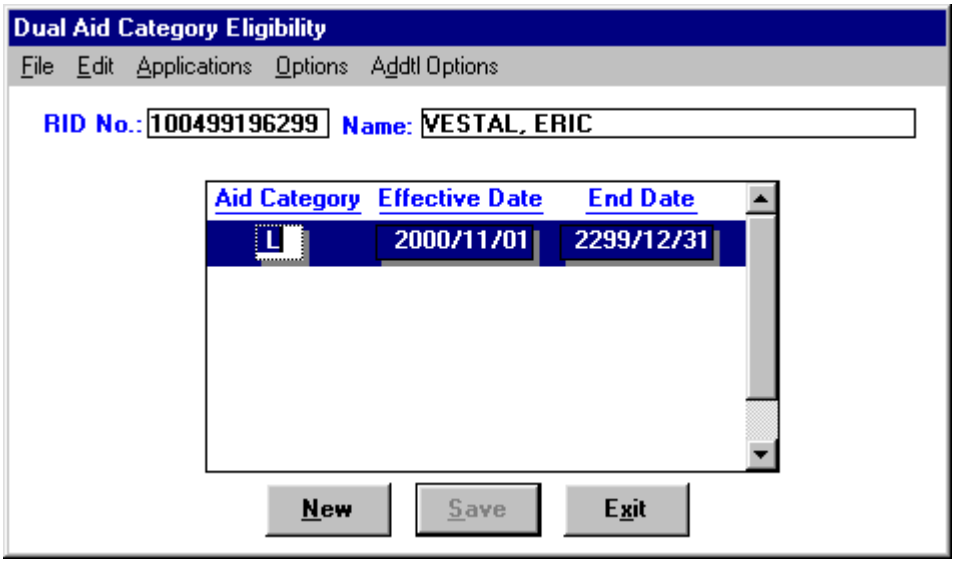

Figure 13.1 – Dual Aid Category Eligibility Window

File	Edit	Applications	Options	
Audit	Copy	Adhoc Reporting	**Base**	**Standard**
Print	Paste	Claims	Eligibility	Replacement
Exit	Cut	Financial	Previous	
Exit Indiana*AIM*		Managed Care	LOC	Name
		MARS	Patient Liab	PCNs
	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift+Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
			Screenings	Premium 150
			Supplement	Premium S15
			Recip Screenings	Dual Aid Eligibility
			Recip Notices	Billing A Mismatches
			Screening Procedures	Billing B Mismatches
			Immunization Procedures	
			System Parms	Billing B Exceptions

Figure 13.2 - Dual Aid Category Eligibility Menu Tree

Figure 13.2 is an illustration of the menu tree for the Dual Aid Category Eligibility window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Dual Aid Category Eligibility window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, and **Options** have the same functions in all the member windows.

Menu Selection: File

These commands are found in Indiana*AIM*:

Audit – Audits changes to the window.

Print – Prints the window.

Exit – Exits the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURs – Accesses the SURs information.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options:

Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: RID No

Description – Unique number assigned by ICES that identifies a member.

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Name

Description – Full name of the member displayed as last name, first name, and middle initial.

Format – 29 alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Aid Category

Description – Member's dual aid category

Format – Six-character alphanumeric

Features – Double-click to open a pop-up window

Valid values:

J

L

LP

Edit – 4012 – Only Non-ICES Aid Category can be added!

To Correct – Verify keying. Select a valid aid category from the Dual Aid Category Codes pop-up window

Edit – 91006 – Field is required!

To Correct – Verify keying. Select a valid aid category from the Dual Aid Category Codes pop-up window if desired.

Field Name: Effective Date

Description – Dual aid category effective date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 4011 – Effective date must be earlier than or equal to the end date!

To Correct – Verify date and date format and re-enter.

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date and format (CCYY/MM/DD)

Edit – 4014-Death Date must be > = End Date !

To Correct – Verify entry and re-enter valid date

Edit – 4015-Eligibility Effective Date must be > = Birth Date!

To Correct – Verify entry and re-enter valid date

Edit – 91003 – Date is required!

To Correct – Enter date in CCYY/MM/DD format.

Edit – 91030 – Date segments may not overlap!

To Correct – Verify date and re-enter.

Field Name: End Date

Description – Dual aid category end date

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify date and date format. (CCYY/MM/DD)

Edit – 91003 – Date is required!

To Correct – Enter date in CCYY/MM/DD format.

Edit – 4013-Death Date must be before or equal to Eligibility End Date!

To Correct – Verify entry and re-enter valid date.

Other Edits

91102 – Please select a record. Occurs when user clicks **Save** without selecting a row

System Information

PBL – RECIP01.PBL

Window – W_RE_DUAL_AID_ELG

W_DUAL_CDE_AID

Data Windows – DW_DUAL_AID_ELG

DW_DUAL_CDE_AID

Menu – M_RE_RESPONSE

System Features

New at the bottom of the Dual Aid Category Eligibility window adds a dual aid category for the member.

Save at the bottom of the window saves changes made to the window.

Exit closes the window.

Section 14: Dual Aid Category Codes Window

Introduction

The Dual Aid Category Codes window stores the valid aid category codes that a member may have if the criteria for dual eligibility are met. This window pops up whenever the user clicks twice on the Aid Category field from of the Dual Aid Category Eligibility window

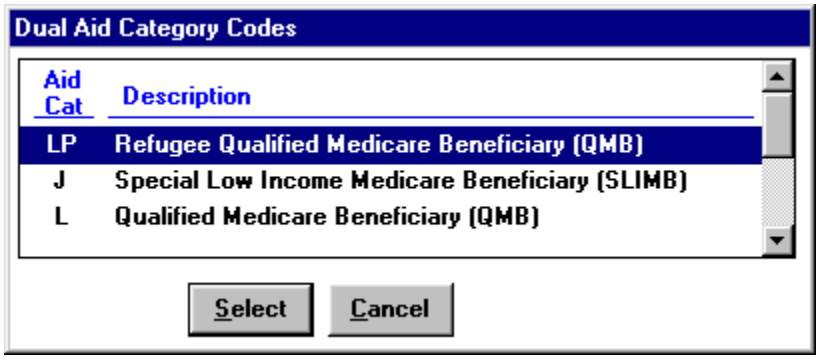

Figure 14.1 – Dual Aid Category Codes Window

Field Information

Field Name: Aid Cat

Description – The member dual aid category

Format – Up to two alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Description

Description – Dual aid category full description

Format – 49 alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

System Information

PBL – RECIP01.PBL

Window – W_RE_DUAL_AID_ELG

W_DUAL_CDE_AID

Data Windows – DW_DUAL_AID_ELG

DW_DUAL_CDE_AID

Menu – M_RE_RESPONSE

System Features

To select a code, highlight the row and double-click or highlight the row and click Select. After double-clicking a row or clicking Select, the window closes and the selected value is placed in the Aid Category code field of the Dual Aid Category Eligibility window.

Click **Cancel** to exit the window with no selection.

Section 15: Billing A Exceptions Window

Introduction

The Billing A Exception window contains information for the Premium Sending table for processing in the next month's cycle. When the row is selected, the user is prompted with a pop-up window that shows the next Buy-In To HCFA Date. This is the date that the next month's cycle processes the premium sending tape. The user may use this date or update it to a future month.

Clears out just before each month's Buy-In cycle starts.

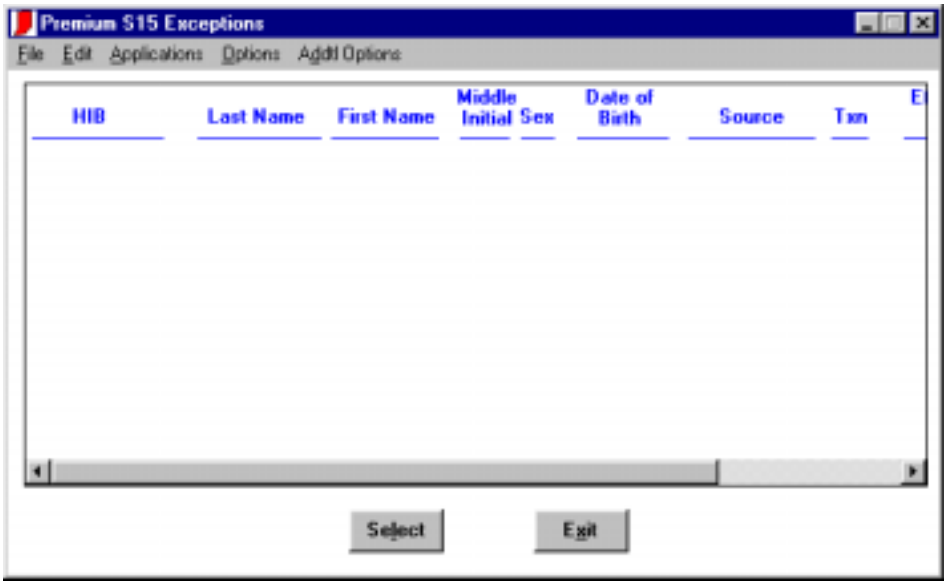

Figure 15.1 – Billing A Exceptions Window

File	Edit	Applications	Options	
Delete	Copy	Adhoc Reporting	**Base**	**Standard**
Print	Paste	Claims	Eligibility	Replacement
Exit	Cut	Financial	Previous	
Audit		Managed Care	LOC	Name
Exit Indiana*AIM*		MARS	Patient Liab	PCNs
	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift+Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 15.2 - Billing A Exception Menu Tree

Figure 15.2 is an illustration of the menu tree for the Billing A Exception window. All menus appear in single-line boxes. The menu

titles on this illustration reflect the overall menu commands and window options on the Billing A Exception window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, and **Options** have the same functions in all the member windows.

Menu Selection: File

These commands delete, print the window, exit the Billing A Exception window and exit Indiana *AIM*.

Delete – Deletes changes to the window

Print – Prints the window.

Exit– Exits the window.

Audit – Audits changes to the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Third Party Liability – Accesses the Third Party Liability windows.

Security – Accesses the Security information.

SURs – Accesses the SURs information

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Last Name

Description – Member's last name

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: First Name

Description – Member's first name

Format – Seven alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Middle Initial

Description – Member's middle initial

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Sex

Description – Member's sex according to HCFA

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Date of Birth

Description – Member's birth date

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: Source

Description – Source of the transaction, created by the ICES update process, a reaction to a transaction from the HCFA Billing, or a manual entry by the state.

Format – One alphabetic character

Valid values:

I – ICES

S – State

H – HCFA

Features – Protected – Defaults to State when user adds or changes data

Edit – None

To Correct – N/a

Field Name: Txn

Description – Buy-In Part A transaction code. It is the first two characters of the four-character numeric code. This code represents either a response to a transaction the State sent or a transaction initiated by HCFA.

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Effective Date

Description – Effective date for the transaction on the Buy-In Part A Billing tape

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: Medicaid ID

Description – Member's identification number according to HCFA.

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Other Features

Highlight a row, by double-clicking it, in the list and use **Select** to put the row back onto the Premium Sending table for processing in the next month's cycle. When the row is selected, the user is prompted with a pop-up window that shows the next Buy-In To HCFA Date.

This is the date that the next month's cycle processes the premium sending tape. The user can use this date or update it to a future month.

Clears out after the premium has run.

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYA_EXCEPTIONS

Data Windows – DW_RE_BUYA_EXCEPTIONS

Menu – M_RE_MAINTENANCE

Section 16: Billing B Exceptions Window

Introduction

The Billing B Exception window contains information for the Premium Sending table for processing in the next month's cycle. When the row is selected, the user is prompted with a pop-up window that shows the next Buy-In To HCFA Date. This is the date that the next month's cycle processes the premium sending tape. The user may use this date or update it to a future month.

Clears out just before each month's buy-in cycle starts.

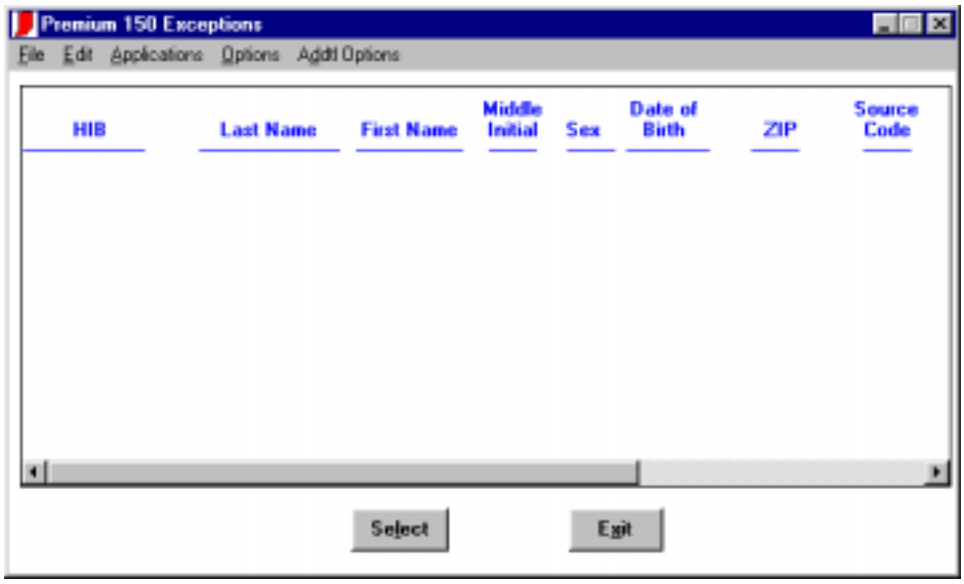

Figure 16.1 – Billing B Exceptions Window

File	Edit	Applications	Options	
Audit	Copy	Adhoc Reporting	**Base**	**Standard**
Print	Paste	Claims	Eligibility	Replacement
Exit	Cut	Financial	Previous	
Exit Indiana*AIM*		Managed Care	LOC	Name
		MARS	Patient Liab	PCNs
	Shift+Del	Prior Authorization	Spenddown	Addresses
	Shift+Ins	Provider	Search	
	Ctl+Ins	Member	Lockin	Lockin Base
		Reference	Medicare	Lock Notification
		Third Party Liability	EPSDT	Lock Prov Notification
		Security	ID Cards	Lock Prov End Notification
		SURS	CSHCS	Lock Utilization
			EOMB Request	
			Potential MC Recip	Medicare Coverage
			Redetermination Date	BuyIn Coverage
			Member Mother RID	Part B Billing
			PMP Assignment	Part A Billing
				Premium 150
			Screenings	Premium S15
			Supplement	Dual Aid Eligibility
			Recip Screenings	Billing A Mismatches
			Recip Notices	Billing B Mismatches
			Screening Procedures	Billing A Exceptions
			Immunization Procedures	Billing B Exceptions
			System Parms	

Figure 16.2 - Billing B Exception Menu Tree

Figure 16.2 is an illustration of the menu tree for the Billing B Exception window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Billing B Exception window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click the command or window option title.
2. After you click the desired option title, a drop-down box appears. Select the command. Use the mouse and double-click or select the underscored letter of each command and press the **Alt** button.

Menu Selections **File**, **Edit**, **Applications**, and **Options** have the same functions in all the member windows.

Menu Selection: File

These commands print the window, delete, exit the Billing B Exception window and exit Indiana*AIM*.

Audit – Audits changes to the window.

Print – Prints the window.

Exit – Exits the window.

*Exit Indiana*AIM – Exits from Indiana*AIM*.

Menu Selection: Edit

These menu commands allow adjustments to the data entered.

Copy – Copies text for transfer to another area or application.

Paste – Pastes text cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

These menu options grant access to all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Accesses the Adhoc Reporting information.

Claims – Accesses the Claims history windows.

Financial – Accesses the Financial windows.

Managed Care – Accesses the Managed Care window.

MARS – Accesses MARS information.

Prior Authorization – Accesses the Prior Authorization windows.

Provider – Accesses the Provider windows.

Member – Accesses the Member windows.

Reference – Accesses the Reference windows.

Security – Accesses the Security information.

SURS – Accesses the SURs information.

Third Party Liability – Accesses the Third Party Liability windows.

Menu Selection: Options

This menu grants access to all the windows that relate to the member functional area.

Member Base – Accesses the Member Base window

Eligibility – Accesses the both standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

Previous – Displays a drop-down list box for Previous. The drop-down list box offers the capability of selecting one of the following options: Names, PCNs, or Addresses.

LOC – Accesses the Level of Care window.

Patient Liab – Accesses the Patient Liability window.

Spenddown – Displays a drop-down list box for Spenddown. The drop-down list box offers the capability of selecting the Spenddown Liability option.

Search – Accesses the Search screen window.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box offers the capability of selecting one of the following options: Lockin Base, Lock Notification, Lock Prov Notification, Lock Prov End Notification, and Lock Utilization.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box offers the capability of selecting one of the following options: Medicare Coverage, Buy-In Coverage, Part B Billing, Part A Billing, Premium 150, Premium S15, Dual Aid Eligibility, Billing A Mismatches, and Billing B Mismatches.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box offers the capability of selecting one of the following options: Screenings, Supplement, Member Screenings, Member Notices, Screening Procedures, Immunization Procedures and System Parms.

ID Cards – Accesses the ID Card window for a specific member.

CSHCS – Accesses the CSHCS Provider Eligibility window.

EOMB Request – Accesses the EOMB Request window.

Potential MC Recip – Accesses the Potential MC Recip window.

Redetermination Date – Accesses the Redetermination Date

Member Mother RID – Accesses the Member Mother RID window.

PMP Assignment – Accesses the PMP Assignment window. Clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

590 Search – Searches for a 590 member

Suspended ICES Dupe – Suspends ICES duplicate

Link History – Displays the link history

Mgd Care Rate Cell – Accesses the Mgd Care Rate Cell

Newborn PMP History – Accesses the Newborn PMP History

Field Information

Field Name: HIB

Description – Member's current Medicare ID

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Last Name

Description – Member's last name

Format – 12 alphanumeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: First Name

Description – Member's first name

Format – Seven alphabetic characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Middle Initial

Description – Member's middle initial

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Sex

Description – Member’s sex according to HCFA

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Date of Birth

Description – Member's birth date

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: ZIP

Description – Member's ZIP code

Format – Five numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Source

Description – Source of the transaction, created by the ICES update process, a reaction to a transaction from the HCFA Billing, or a manual entry by the state.

Format – One alphabetic character

Valid values:

I – ICES

S – State

H – HCFA

Features – Protected – Defaults to State when user adds or changes data

Edit – None

To Correct – N/a

Field Name: Elig Code

Description – Contains the HCFA eligibility code of L, M, P, or Z. This code represents either a response to a transaction the State sent or a transaction initiated by HCFA.

Format – One alphabetic character

Features – Protected

Edit – None

To Correct – N/a

Field Name: Txn

Description – Buy-In Part A transaction code. It is the first two characters of the four-character numeric code. This code represents either a response to a transaction the State sent or a transaction initiated by HCFA.

Format – Two numeric characters

Features – Protected

Edit – None

To Correct – N/a

Field Name: Effective Date

Description – Effective date for the transaction on the Buy-In Part B Billing tape

Format – Eight numeric characters (CCYYMMDD)

Features – Protected

Edit – None

To Correct – N/a

Field Name: Medicaid ID

Description – Member's identification number according to HCFA

Format – 12 numeric characters

Features – Protected

Edit – None

To Correct – N/a

Other Features

Highlight a row, by double-clicking it, in the list and use **Select** to put the row back onto the Premium Sending table for processing in the next month's cycle. When the row is selected the user is prompted with a pop-up window that shows the next Buy-In To HCFA Date. This is the date that the next month's cycle processes the premium sending tape. The user may use this date or update it to a future month.

Clears out just before each month's buy-in cycle starts.

System Information

PBL – RECIP02.PBL

Window – W_RE_BUYB_EXCEPTIONS

Data Windows – DW_RE_BUYB_EXCEPTIONS

Menu – M_RE_MAINTENANCE

Glossary

1115(a) Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by HCFA. See also *Health Care Financing Administration, PACE, Waiver*.

11971 State form 11971; see *8A*.

1261A Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility.*

1500 This is a claim form used by participating Medicaid providers to bill medical and medically related services.

1902(a)(1) Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness.*

1902(a)(10) Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.

1902(a)(23) Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*

1902(r)(2) Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.

1903(m) Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.

1915(b) Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c) Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*

1915(c)(7)(b) Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.

1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission.
450B	Certification by Physician for Long Term Care Services.
590 Program	A program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
7748	State Form 7748, Medicaid Financial Report.
8A	DPW Form 8A State Form 11971, *Notice to Provider of Member Deductible.* Used to relay member spenddown information to providers.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAP	American Academy of Pediatrics.
ABA	American Banking Association.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.
ACSW	Academy of Certified Social Worker.
ADA	American Dental Association.
ADC	Adult Day Care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.

Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children (AFDC) is replaced with Temporary Assistance for Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance members, who are 65 years old or older, or members under any other category who are entitled to benefits under Medicare.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.
Aid to the Blind (AB)	A classification or category of members eligible for benefits under the Medicaid Program.
AIM	Advanced Information Management.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.

Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to obtain pertinent information concerning member eligibility, benefit limitation, check information, and PA for IHCP participants.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.

billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider who prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.
Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of Medicaid services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits/procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal, a document from the Indiana State Department of Health (ISDH) that certifies institutional providers.
C519	Authorization for Member Liability Deviation, generated by the Medicaid member's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)

case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CDFC	County Division of Family and Children.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services; health-care plan for the uniformed services outside the military health-care system, now know as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).

Children's Special Health Care Services(CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for Medicaid claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP. See also *Member*.
CMHC	Community Mental Health Center.
CMS	Centers for Medicare & Medicaid Services. Effective August 2001, this is the new name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. It was formerly known as the Health Care Financing Administration for HCFA.
co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after his/her deductible has been met. The co-insurance or a percentage amount is paid by Medicaid if the member is eligible for Medicaid. See also *Cost Sharing*.

Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
co-payment or co-pay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
core contractor	Vendor that successfully bids *on Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services.*
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.

cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for IHCP using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members.
CP	Clinical psychologist.
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CPS	Child Protective Services.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central processing unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRNA	Certified registered nurse anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to Medicaid benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.

CSHCS	Children's Special Health Care Services. A state-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Clinical social worker.
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP, including state staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
data element	A specific unit of information having a unique meaning.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug determined to be less than effective (LTE); not covered by the IHCP.
designee	Duly authorized representative of a person holding a superior position.
detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition.*
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the CMS.
DHS	Department of Health Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.

disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples include wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana agency overseeing agency compliance with all State data processing statutes, policies, and procedures.
DPOC	Data Processing Oversight Commission. Indiana agency providing oversight and review of all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Office of Medicaid Policy and Planning.
DPW Form 8A	See *8A*.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the State Medicaid Program.
Drug Efficacy Study Implementation (DESI)	Listed drugs considered to be less than effective by the U.S. Food and Drug Administration. See also *Notice of Opportunity for Hearing (NOOH).*
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series is usually associated with the reference, as well.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.

DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; primarily seen as LTC, long-term care; also seen as NH or NF.
ECM	Electronic claims management. Claims submitted in electronic format rather than paper. See *ECC, EMC*.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
eligible member	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See *ECC, ECS*.
EMS	Emergency medical service.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's RA.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's RA.

EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible members under 21 years old, offering free preventive health care services, such as screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End-stage renal disease.
EST	Eastern Standard Time, which is also Indianapolis local time.
EVS	Eligibility Verification System. System used by providers to verify member eligibility using a point-of-sale device, online PC access, or an AVR system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.

field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
fiscal month	Monthly time interval in a fiscal year.
fiscal year	Twelve-month period between settlements of financial accounts.
fiscal year – federal	October 1 - September 30.
fiscal year – Indiana	July 1 - June 30.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that IHCP beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.

FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as “paper” and “manual”.
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel.
HCFA	Health Care Financing Administration. This is the previous name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. Effective August 2001, it is called the Centers for Medicare & Medicaid Services.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana’s preventive care program for Medicaid members under 21 years of age. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.

HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPP	Health insurance premium payments.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*
Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.

Hoosier Healthwise	IHCP managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HPB	Health Professions Bureau.
HRI	Health-related items.
IAC	Indiana Administrative Code. State government agency administrative procedures.
IC	Indiana code.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IMCA	Indiana Motor Carrier Authority.
IMD	Institutions for mental disease.

IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPP	Individualized Program Plan.
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health. Currently known as the Indiana State Department of Health (ISDH).
ISDH	Indiana State Department of Health. Previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.

ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed practical nurse.
LSL	Lower specification limit, pertains to quality control charts.
LTC	Long term care. Facilities that supply long-term residential care to members.

LTE	Less than effective drugs.
M/M	Medicare/Medicaid.
MAC	Maximum allowable charge for drugs as specified by the federal government.
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	Managed Care for Persons with Disabilities. One of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*

Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. Members in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A and/or Part B for services authorized by Medicare Part A and/or Part B.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*.

mental retardation	Significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral
misutilization	Any usage of the IHCP by any of its providers or members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is Indiana*AIM*.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team. FSSA Unit that makes decisions regarding disability determination.
MSW	Master of Social Work.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NEC	Not elsewhere classified.

NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to online, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility.
NH	Nursing home.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act. Federal laws that direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.
OMNI	Point-of-sale device used by providers to scan member ID cards to determine eligibility.

OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter (in reference to drugs).
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs Medicaid functions under the direction of the single state agency. The single state agency may perform all Medicaid functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a Medicaid member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a Medicaid member resulting from the failure of the contractor to use available information or to process correctly.
override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.

PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by Medicaid.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by Medicaid that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a member of services.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participating members	Individuals who receive Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve Medicaid members and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term-care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.

payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Members are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the member—24 hours a day, seven days a week.
PCN	Primary care network.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device that enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PGA	Peer group average.
PHC	Primary home care. Medicaid-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.

physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
plan of care	A formal plan developed to address the specific needs of an individual; links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO)*.
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.

prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities needed to meet all federal Pro-DUR requirements and all DUR requirements.
profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that provides a covered IHCP service to an IHCP member.
provider enrollment application	Required document for all providers who provide services to IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor, dentist.
PSRO	Professional standards review organization.

purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBA	Room and board assistance.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF members, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by OMPP.

reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Member*.
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual members.
member restriction	A limitation or review status placed on a member that limits or controls access to the IHCP to a greater extent than for other nonrestricted members.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.

rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Restrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic.
RID	Member identification (ID) number; the unique number assigned to an individual who is eligible for Medical Assistance Programs services.
risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool*.
RN	Registered nurse.
RNC	Registered nurse clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment
RPT	Registered physical therapist.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
SBOH	State Board of Health. Previous term for the State Department of Health.

screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with an MCO's health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.

specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
spenddown	Process whereby Medicaid eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	The state of Indiana and any of its departments, agencies, and public agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.

State Medicaid Office Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the Medicaid program in Indiana.

State Plan The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.

status Condition of a claim at a given time; such as paid, pended, denied, and so forth.

stop-loss insurance Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year. See also *Reinsurance*.

subcontractor Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

submission The act of a provider sending billings to EDS for payment.

subsystem A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.

SUR Surveillance and Utilization Review. Refers to system functions and activities mandated by the CMS that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements:

. statistical analysis
. exception processing
. provider and member profiles
. retrospective detection of claims processing edit/audit failures/errors
. retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards
. retrospective detection of fraud and abuse by providers or members
. sophisticated data and claim analysis including sampling and reporting
. general access and processing features
. general reports and output

suspended transaction A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).

suspense file Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).

systems analyst/engineer	Responsible for performing the following activities:). Detailed system/program design l. System/program development 2. Maintenance and modification analysis/resolution 3. User needs analysis 4. User training support 5. Development of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.

Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all members to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirments of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the members to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization review.

UR	Utilization Review. A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VFC	Vaccines for Children program.
VFC	Vaccine for Children program.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.

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